Form 5500

Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

OMB Nos. 1210 - 0110
1210 - 0089

2016

This Form is Open to Public Inspection

Complete all entries in accordance with the instructions to the Form 5500.

Part I · Annual Report Identification Information

For calendar plan year 2016 or fiscal plan year beginning January 01, 2016 , and ending December 31, 2016

A a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions)for ☐ a multiemployer plan; ☐ a multiple-employer plan; ☐ a DFE (specify) ☒ a single-employer plan;

B This return/report is: ☐ the first return/report; ☐ the final return/report; ☐ an amended return/report; ☐ a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here ☐

D Check box if filling under: ☒ Form 5558; ☐ automatic extension; ☐ the DFVC program; ☐ special extension (enter description)

Part II · Basic Plan Information – enter all requested information.

1a Name of plan

FABSOUTH LLC PREMIUM CONVERSION PLAN

1b Three-digit plan number (PN) 501

1c Effective date of plan May 17, 2004

2a Plan sponsor's name and address, including room or suite number (Employer, if for a single-employer plan)

FABSOUTH LLC
721 NE 44TH STREET
FT. LAUDERDALE FL 33334-3150

2b Employer Identification Number (EIN) [redacted]1961

2c Sponsor's telephone number 954-938-5800

2d Business code (see instructions) 332300

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.
Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

	09/06/2017	TIMOTHY BURNS
Signature of plan administrator	Date	Enter name of individual signing as plan administrator
Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
Signature of DFE	Date	Enter name of individual signing as DFE

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. **Form 5500 (2016) v.092308.1**

3a Plan administrator's name and address (if same as plan sponsor, enter"Same")

3b Administrator's EIN

3c Administrator's telephone number

4	If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below: **a** Sponsor's name		**4b** EIN **4c** PN
5	Total number of participants at the beginning of the plan year	**5**	865
6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans only complete lines **6a(1), 6a(2), 6b, 6c,** and **6d**)		
a(1)	Total active number of participants at the beginning of the plan year	**6a(1)**	862
a(2)	Total active number of participants at the end of the plan year	**6a(2)**	
b	Retired or separated participants receiving benefits	**6b**	4
c	Other retired or separated participants entitled to future benefits	**6c**	
d	Subtotal. Add lines **6a(2), 6b,** and **6c**	**6d**	834
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**6e**	
f	Total. Add lines **6d** and **6e**	**6f**	
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	0

8a If the plan provides **pension benefits**, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:

b If the plan provides **welfare benefits**, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:

4A **4B** **4D** **4E** **4F** **4H** **4L**

9a Plan funding arrangement (check all that apply)
- **(1)** [X] Insurance
- **(2)** [ ] Section 412(e)(3) insurance contracts
- **(3)** [ ] Trust
- **(4)** [X] General assets of the sponsor

9b Plan benefit arrangement (check all that apply)
- **(1)** [X] Insurance
- **(2)** [ ] Section 412(e)(3) insurance contracts
- **(3)** [ ] Trust
- **(4)** [X] General assets of the sponsor

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached,and, where indicated, enter the number attached (See instructions)

a Pension Schedules
- **(1)** [ ] **R** (Retirement Plan Information)
- **(2)** [ ] **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information)- signed by the plan actuary
- **(3)** [ ] **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

b General Schedules
- **(1)** [ ] **H** (Financial Information)
- **(2)** [ ] **I** (Financial Information – Small Plan)
- **(3)** [X] 8 **A** (Insurance Information)
- **(4)** [ ] **C** (Service Provider Information)
- **(5)** [ ] **D** (DFE/Participating Plan Information)
- **(6)** [ ] **G** (Financial Transaction Schedules)

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

11a If the plan provides welfare benefits, was the plan subject to Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2)..... [ ] Yes [X] No
If "Yes" is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with M-1 filing requirements? (See instructions and 29 CFR 2520.101-2)..... [ ] Yes [ ] No

11c Enter the Receipt Confirmation Code for the 2016 Form M-1 annual report. If the plan was not required to file the 2016 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.) Receipt Confirmation Code

SCHEDULE A Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210 - 0110

2016

This Form is Open to Public Inspection

For the calendar plan year 2016 or fiscal plan year beginning January 01, 2016, and ending December 31, 2016

A Name of plan

FABSOUTH LLC PREMIUM CONVERSION PLAN

B Three-digit plan number (PN) 501

C Plan sponsor's name as shown on line 2a of Form 5500

FABSOUTH LLC

D Employer Identification Number (EIN) [redacted]1961

Part I · **Information Concerning Insurance Contract Coverage, Fees, and Commissions.** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information

(a) Name of insurance carrier

AIG INSURANCE COMPANY OF CANADA

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Aproximate number of persons covered at end of policy or contract year	Policy or contract year **(f)** From	**(g)** To
[redacted]8210	19402	BSC 9022705A	830	01/01/2016	12/31/2016

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid

(b) Total amount of fees paid

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid **(c)** Amount	**(d)** Purpose	**(e)** Organization code

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. **Schedule A (Form 5500) 2016 v.092308.1**

Part II · **Investment and Annuity Contract Information** Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end **4**

5 Current value of plan's interest under this contract in separate accounts at year end **5**

6 Contracts With Allocated Funds

a State the basis of premium rates

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquision or retention of the contract or policy, enter amount **6d**

Specify nature of costs

e Type of contract **(1)** ☐ individual policies **(2)** ☐ group deferred annuity **(3)** ☐ other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract **(1)** ☐ deposit administration **(2)** ☐ immediate participation guarantee **(3)** ☐ guaranteed investment **(4)** ☐ other

b Balance at the end of the previous year **7b**

c Additions: (1) Contributions deposited during the year **7c(1)**

(2) Dividends and credits **7c(2)**

(3) Interest credited during the year **7c(3)**

(4) Transferred from separate account **7c(4)**

(5) Other (specify below) **7c(5)**

(6) Total additions **7c(6)**

d	Total of balance and additions (add **b** and **c** (6))		**7d**
e	Deductions:		
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**	
	(2) Administration charge made by carrier	**7e(2)**	
	(3) Transferred to separate account	**7e(3)**	
	(4) Other (specify below)	**7e(4)**	
	(5) Total deductions		**7e(5)**
f	Balance at the end of the current year (subtract **e**(5) from **d**)		**7f**

Part III **Welfare Benefit Contract Information**

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

a ☐ Health (other than dental or vision)	**b** ☐ Dental	**c** ☐ Vision	**d** ☐ Life insurance
e ☐ Temporary disablility (accident and sickness)	**f** ☐ Long-term disability	**g** ☐ Supplemental unemployment	**h** ☐ Prescription drug
i ☐ Stop loss (large deductible)	**j** ☐ HMO contract	**k** ☐ PPO contract	**l** ☐ Indemnity contract

m ☒ Other (specify) ACCIDENTAL DEATH AND DISMEMBERMENT

9 Experience related contracts

a	Premiums: (1) Amount received	**9a(1)**		
	(2) Increase (decrease) in amount due but unpaid	**9a(2)**		
	(3) Increase (decrease) in unearned premium reserve	**9a(3)**		
	(4) Earned ((1)+(2)-(3))		**9a(4)**	
b	Benefit charges: (1) Claims paid	**9b(1)**		
	(2) Increase (decrease) in claim reserves	**9b(2)**		
	(3) Incurred claims (add (1) and (2))		**9b(3)**	
	(4) Claims charged		**9b(4)**	
c	Remainder of premium: (1) Retention charges (on an accrual basis) –			
	(A) Commissions	**9c(1)(A)**		
	(B) Administrative service or other fees	**9c(1)(B)**		
	(C) Other specific acquisition costs	**9c(1)(C)**		
	(D) Other expenses	**9c(1)(D)**		
	(E) Taxes	**9c(1)(E)**		
	(F) Charges for risks or other contingencies	**9c(1)(F)**		
	(G) Other retention charges	**9c(1)(G)**		
	(H) Total Retention		**9c(1)(H)**	
	(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)		**9c(2)**	
d	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		**9d(1)**	
	(2) Claim reserves		**9d(2)**	
	(3) Other reserves		**9d(3)**	
e	Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).)		**9e**	

10 Nonexperience-rated contracts

a	Total premiums or subscription charges paid to carrier	**10a**	$9,720
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount	**10b**	

Specify nature of costs below:

Part IV **Provision of Information**

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is “Yes,” specify the information not provided.

SCHEDULE A Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210 - 0110

2016

This Form is Open to Public Inspection

For the calendar plan year 2016 or fiscal plan year beginning January 01, 2016, and ending December 31, 2016

A Name of plan

FABSOUTH LLC PREMIUM CONVERSION PLAN

B Three-digit plan number (PN) 501

C Plan sponsor's name as shown on line 2a of Form 5500

FABSOUTH LLC

D Employer Identification Number (EIN) [redacted]1961

Part I · **Information Concerning Insurance Contract Coverage, Fees, and Commissions.** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information

(a) Name of insurance carrier

CIGNA HEALTH AND LIFE INSURANCE COMPANY AND AFFILIATES

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Aproximate number of persons covered at end of policy or contract year	Policy or contract year (f) From	(g) To
[redacted]1071	67369	2499612	1323	01/01/2016	12/31/2016

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
$160,309	$3,464

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC
4565 PAYSPHERE CIRCLE
CHICAGO IL 60674

(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount	(d) Purpose	(e) Organization code
$160,309	$3,464	SERVICE/GEN AGENT FEES	3

Part II · **Investment and Annuity Contract Information**

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end **4**

5 Current value of plan's interest under this contract in separate accounts at year end **5**

6 Contracts With Allocated Funds

a State the basis of premium rates

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquision or retention of the contract or policy, enter amount **6d**

Specify nature of costs

e Type of contract **(1)** ☐ individual policies **(2)** ☐ group deferred annuity **(3)** ☐ other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract **(1)** ☐ deposit administration **(2)** ☐ immediate participation guarantee **(3)** ☐ guaranteed investment **(4)** ☐ other

b Balance at the end of the previous year **7b**

c Additions: (1) Contributions deposited during the year **7c(1)**

(2) Dividends and credits **7c(2)**

(3) Interest credited during the year **7c(3)**

(4) Transferred from separate account **7c(4)**

(5) Other (specify below)	7c(5)		
(6) Total additions		7c(6)	
d Total of balance and additions (add **b** and **c** (6))		7d	
e Deductions:			
(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
(2) Administration charge made by carrier	7e(2)		
(3) Transferred to separate account	7e(3)		
(4) Other (specify below)	7e(4)		
(5) Total deductions		7e(5)	
f Balance at the end of the current year (subtract **e**(5) from **d**)		7f	

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

a ☒ Health (other than dental or vision)	**b** ☒ Dental	**c** ☐ Vision	**d** ☐ Life insurance
e ☐ Temporary disablility (accident and sickness)	**f** ☐ Long-term disability	**g** ☐ Supplemental unemployment	**h** ☒ Prescription drug
i ☐ Stop loss (large deductible)	**j** ☒ HMO contract	**k** ☐ PPO contract	**l** ☒ Indemnity contract
m ☐ Other (specify)			

9 Experience related contracts

a Premiums: (1) Amount received	9a(1)	$5,852,110		
(2) Increase (decrease) in amount due but unpaid	9a(2)			
(3) Increase (decrease) in unearned premium reserve	9a(3)			
(4) Earned ((1)+(2)-(3))			9a(4)	$5,852,110
b Benefit charges: (1) Claims paid	9b(1)	$5,412,398		
(2) Increase (decrease) in claim reserves	9b(2)	$51,420		
(3) Incurred claims (add (1) and (2))			9b(3)	$5,463,818
(4) Claims charged			9b(4)	$5,463,818
c Remainder of premium: (1) Retention charges (on an accrual basis) –				
(A) Commissions	9c(1)(A)	$147,471		
(B) Administrative service or other fees	9c(1)(B)			
(C) Other specific acquisition costs	9c(1)(C)			
(D) Other expenses	9c(1)(D)	$864,747		
(E) Taxes	9c(1)(E)	$117,042		
(F) Charges for risks or other contingencies	9c(1)(F)			
(G) Other retention charges	9c(1)(G)			
(H) Total Retention			9c(1)(H)	$1,129,260
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)			9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			9d(1)	
(2) Claim reserves			9d(2)	$937,152
(3) Other reserves			9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).)			9e	

10 Nonexperience-rated contracts

a Total premiums or subscription charges paid to carrier	10a	$951,221
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount	10b	

Specify nature of costs below:

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is “Yes,” specify the information not provided.

SCHEDULE A Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210 - 0110

2016

This Form is Open to Public Inspection

For the calendar plan year 2016 or fiscal plan year beginning January 01, 2016, and ending December 31, 2016

A Name of plan

FABSOUTH LLC PREMIUM CONVERSION PLAN

B Three-digit plan number (PN) 501

C Plan sponsor's name as shown on line 2a of Form 5500

FABSOUTH LLC

D Employer Identification Number (EIN) [redacted]1961

Part I · **Information Concerning Insurance Contract Coverage, Fees, and Commissions.** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information

(a) Name of insurance carrier

LIFE INSURANCE COMPANY OF NORTH AMERICA

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Aproximate number of persons covered at end of policy or contract year	Policy or contract year (f) From	(g) To
[redacted]749	65498	FLI960258	830	01/01/2016	12/31/2016

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid: $2,136

(b) Total amount of fees paid:

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC
4565 PAYSPHERE CIRCLE
CHICAGO IL 60674

(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount	(d) Purpose	(e) Organization code
$2,136			3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. **Schedule A (Form 5500) 2016 v.092308.1**

Part II · **Investment and Annuity Contract Information** Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end **4**

5 Current value of plan's interest under this contract in separate accounts at year end **5**

6 Contracts With Allocated Funds

a State the basis of premium rates

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquision or retention of the contract or policy, enter amount **6d**

Specify nature of costs

e Type of contract **(1)** ☐ individual policies **(2)** ☐ group deferred annuity **(3)** ☐ other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract **(1)** ☐ deposit administration **(2)** ☐ immediate participation guarantee **(3)** ☐ guaranteed investment **(4)** ☐ other

b Balance at the end of the previous year **7b**

c Additions: (1) Contributions deposited during the year **7c(1)**

(2) Dividends and credits **7c(2)**

(3) Interest credited during the year **7c(3)**

(4) Transferred from separate account **7c(4)**

(5) Other (specify below) **7c(5)**

(6) Total additions **7c(6)**

d Total of balance and additions (add **b** and **c** (6)) **7d**

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)**

(2) Administration charge made by carrier **7e(2)**

(3) Transferred to separate account **7e(3)**

(4) Other (specify below) **7e(4)**

(5) Total deductions **7e(5)**

f Balance at the end of the current year (subtract **e**(5) from **d**) **7f**

Part III **Welfare Benefit Contract Information**

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

a ☐ Health (other than dental or vision) **b** ☐ Dental **c** ☐ Vision **d** ☒ Life insurance

e ☐ Temporary disablility (accident and sickness) **f** ☐ Long-term disability **g** ☐ Supplemental unemployment **h** ☐ Prescription drug

i ☐ Stop loss (large deductible) **j** ☐ HMO contract **k** ☐ PPO contract **l** ☐ Indemnity contract

m ☐ Other (specify)

9 Experience related contracts

a Premiums: (1) Amount received **9a(1)**

(2) Increase (decrease) in amount due but unpaid **9a(2)**

(3) Increase (decrease) in unearned premium reserve **9a(3)**

(4) Earned ((1)+(2)-(3)) **9a(4)**

b Benefit charges: (1) Claims paid **9b(1)**

(2) Increase (decrease) in claim reserves **9b(2)**

(3) Incurred claims (add (1) and (2)) **9b(3)**

(4) Claims charged **9b(4)**

c Remainder of premium: (1) Retention charges (on an accrual basis) –

(A) Commissions **9c(1)(A)**

(B) Administrative service or other fees **9c(1)(B)**

(C) Other specific acquisition costs **9c(1)(C)**

(D) Other expenses **9c(1)(D)**

(E) Taxes **9c(1)(E)**

(F) Charges for risks or other contingencies **9c(1)(F)**

(G) Other retention charges **9c(1)(G)**

(H) Total Retention **9c(1)(H)**

(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.) **9c(2)**

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement **9d(1)**

(2) Claim reserves **9d(2)**

(3) Other reserves **9d(3)**

e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) **9e**

10 Nonexperience-rated contracts

a Total premiums or subscription charges paid to carrier **10a** $182,678

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount **10b**

Specify nature of costs below:

Part IV **Provision of Information**

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is “Yes,” specify the information not provided.

SCHEDULE A Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210 - 0110

2016

This Form is Open to Public Inspection

For the calendar plan year 2016 or fiscal plan year beginning January 01, 2016, and ending December 31, 2016

A Name of plan

FABSOUTH LLC PREMIUM CONVERSION PLAN

B Three-digit plan number (PN) 501

C Plan sponsor's name as shown on line 2a of Form 5500

FABSOUTH LLC

D Employer Identification Number (EIN) [redacted]1961

Part I · **Information Concerning Insurance Contract Coverage, Fees, and Commissions.** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information

(a) Name of insurance carrier

LIFE INSURANCE COMPANY OF NORTH AMERICA

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Aproximate number of persons covered at end of policy or contract year	Policy or contract year (f) From	(g) To
[redacted]3749	65498	LK 751892	830	01/01/2016	12/31/2016

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid: $2,000

(b) Total amount of fees paid:

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC
4565 PAYSPHERE CIRCLE
CHICAGO IL 60674

(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount	(d) Purpose	(e) Organization code
$2,000			3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. **Schedule A (Form 5500) 2016 v.092308.1**

Part II · **Investment and Annuity Contract Information** Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end **4**

5 Current value of plan's interest under this contract in separate accounts at year end **5**

6 Contracts With Allocated Funds

a State the basis of premium rates

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquision or retention of the contract or policy, enter amount **6d**

Specify nature of costs

e Type of contract **(1)** ☐ individual policies **(2)** ☐ group deferred annuity **(3)** ☐ other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract **(1)** ☐ deposit administration **(2)** ☐ immediate participation guarantee **(3)** ☐ guaranteed investment **(4)** ☐ other

b Balance at the end of the previous year **7b**

c Additions: (1) Contributions deposited during the year **7c(1)**

(2) Dividends and credits **7c(2)**

(3) Interest credited during the year **7c(3)**

(4) Transferred from separate account **7c(4)**

(5) Other (specify below) **7c(5)**

(6) Total additions **7c(6)**

d Total of balance and additions (add **b** and **c** (6)) **7d**

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)**

(2) Administration charge made by carrier **7e(2)**

(3) Transferred to separate account **7e(3)**

(4) Other (specify below) **7e(4)**

(5) Total deductions **7e(5)**

f Balance at the end of the current year (subtract **e**(5) from **d**) **7f**

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

a ☐ Health (other than dental or vision) **b** ☐ Dental **c** ☐ Vision **d** ☐ Life insurance

e ☒ Temporary disablility (accident and sickness) **f** ☐ Long-term disability **g** ☐ Supplemental unemployment **h** ☐ Prescription drug

i ☐ Stop loss (large deductible) **j** ☐ HMO contract **k** ☐ PPO contract **l** ☐ Indemnity contract

m ☐ Other (specify)

9 Experience related contracts

a Premiums: (1) Amount received **9a(1)**

(2) Increase (decrease) in amount due but unpaid **9a(2)**

(3) Increase (decrease) in unearned premium reserve **9a(3)**

(4) Earned ((1)+(2)-(3)) **9a(4)**

b Benefit charges: (1) Claims paid **9b(1)**

(2) Increase (decrease) in claim reserves **9b(2)**

(3) Incurred claims (add (1) and (2)) **9b(3)**

(4) Claims charged **9b(4)**

c Remainder of premium: (1) Retention charges (on an accrual basis) –

(A) Commissions **9c(1)(A)**

(B) Administrative service or other fees **9c(1)(B)**

(C) Other specific acquisition costs **9c(1)(C)**

(D) Other expenses **9c(1)(D)**

(E) Taxes **9c(1)(E)**

(F) Charges for risks or other contingencies **9c(1)(F)**

(G) Other retention charges **9c(1)(G)**

(H) Total Retention **9c(1)(H)**

(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.) **9c(2)**

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement **9d(1)**

(2) Claim reserves **9d(2)**

(3) Other reserves **9d(3)**

e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) **9e**

10 Nonexperience-rated contracts

a Total premiums or subscription charges paid to carrier **10a** $170,854

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount **10b**

Specify nature of costs below:

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is “Yes,” specify the information not provided.

SCHEDULE A Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210 - 0110

2016

This Form is Open to Public Inspection

For the calendar plan year 2016 or fiscal plan year beginning January 01, 2016, and ending December 31, 2016

A Name of plan

FABSOUTH LLC PREMIUM CONVERSION PLAN

B Three-digit plan number (PN) 501

C Plan sponsor's name as shown on line 2a of Form 5500

FABSOUTH LLC

D Employer Identification Number (EIN) [redacted]1961

Part I · **Information Concerning Insurance Contract Coverage, Fees, and Commissions.** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information

(a) Name of insurance carrier

LIFE INSURANCE COMPANY OF NORTH AMERICA

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Aproximate number of persons covered at end of policy or contract year	Policy or contract year **(f)** From	**(g)** To
[redacted]3749	65498	LK 964791	830	01/01/2016	12/31/2016

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid: $1,275

(b) Total amount of fees paid:

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC
4565 PAYSPHERE CIRCLE
CHICAGO IL 60674

(b) Amount of sales and base commissions paid	Fees and other commissions paid **(c)** Amount	**(d)** Purpose	**(e)** Organization code
$1,275			3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. **Schedule A (Form 5500) 2016 v.092308.1**

Part II · **Investment and Annuity Contract Information** Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end **4**

5 Current value of plan's interest under this contract in separate accounts at year end **5**

6 Contracts With Allocated Funds

a State the basis of premium rates

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquision or retention of the contract or policy, enter amount **6d**

Specify nature of costs

e Type of contract **(1)** ☐ individual policies **(2)** ☐ group deferred annuity **(3)** ☐ other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract **(1)** ☐ deposit administration **(2)** ☐ immediate participation guarantee **(3)** ☐ guaranteed investment **(4)** ☐ other

b Balance at the end of the previous year **7b**

c Additions: (1) Contributions deposited during the year **7c(1)**

(2) Dividends and credits **7c(2)**

(3) Interest credited during the year **7c(3)**

(4) Transferred from separate account **7c(4)**

(5) Other (specify below) **7c(5)**

(6) Total additions **7c(6)**

d Total of balance and additions (add **b** and **c** (6)) **7d**

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)**

(2) Administration charge made by carrier **7e(2)**

(3) Transferred to separate account **7e(3)**

(4) Other (specify below) **7e(4)**

(5) Total deductions **7e(5)**

f Balance at the end of the current year (subtract **e**(5) from **d**) **7f**

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

a ☐ Health (other than dental or vision) **b** ☐ Dental **c** ☐ Vision **d** ☐ Life insurance

e ☐ Temporary disablility (accident and sickness) **f** ☒ Long-term disability **g** ☐ Supplemental unemployment **h** ☐ Prescription drug

i ☐ Stop loss (large deductible) **j** ☐ HMO contract **k** ☐ PPO contract **l** ☐ Indemnity contract

m ☐ Other (specify)

9 Experience related contracts

a Premiums: (1) Amount received **9a(1)**

(2) Increase (decrease) in amount due but unpaid **9a(2)**

(3) Increase (decrease) in unearned premium reserve **9a(3)**

(4) Earned ((1)+(2)-(3)) **9a(4)**

b Benefit charges: (1) Claims paid **9b(1)**

(2) Increase (decrease) in claim reserves **9b(2)**

(3) Incurred claims (add (1) and (2)) **9b(3)**

(4) Claims charged **9b(4)**

c Remainder of premium: (1) Retention charges (on an accrual basis) –

(A) Commissions **9c(1)(A)**

(B) Administrative service or other fees **9c(1)(B)**

(C) Other specific acquisition costs **9c(1)(C)**

(D) Other expenses **9c(1)(D)**

(E) Taxes **9c(1)(E)**

(F) Charges for risks or other contingencies **9c(1)(F)**

(G) Other retention charges **9c(1)(G)**

(H) Total Retention **9c(1)(H)**

(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.) **9c(2)**

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement **9d(1)**

(2) Claim reserves **9d(2)**

(3) Other reserves **9d(3)**

e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) **9e**

10 Nonexperience-rated contracts

a Total premiums or subscription charges paid to carrier **10a** $108,948

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount **10b**

Specify nature of costs below:

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is “Yes,” specify the information not provided.

SCHEDULE A Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210 - 0110

2016

This Form is Open to Public Inspection

For the calendar plan year 2016 or fiscal plan year beginning January 01, 2016, and ending December 31, 2016

A Name of plan

FABSOUTH LLC PREMIUM CONVERSION PLAN

B Three-digit plan number (PN) 501

C Plan sponsor's name as shown on line 2a of Form 5500

FABSOUTH LLC

D Employer Identification Number (EIN) [redacted]1961

Part I · **Information Concerning Insurance Contract Coverage, Fees, and Commissions.** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information

(a) Name of insurance carrier

LIFE INSURANCE COMPANY OF NORTH AMERICA

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Aproximate number of persons covered at end of policy or contract year	Policy or contract year (f) From	(g) To
[redacted]3749	65498	OK 968488	830	01/01/2016	12/31/2016

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid: $248

(b) Total amount of fees paid:

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC
4565 PAYSPHERE CIRCLE
CHICAGO IL 60674

(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount	(d) Purpose	(e) Organization code
$248			3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. **Schedule A (Form 5500) 2016 v.092308.1**

Part II · **Investment and Annuity Contract Information** Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end **4**

5 Current value of plan's interest under this contract in separate accounts at year end **5**

6 Contracts With Allocated Funds

a State the basis of premium rates

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquision or retention of the contract or policy, enter amount **6d**

Specify nature of costs

e Type of contract **(1)** ☐ individual policies **(2)** ☐ group deferred annuity **(3)** ☐ other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract **(1)** ☐ deposit administration **(2)** ☐ immediate participation guarantee **(3)** ☐ guaranteed investment **(4)** ☐ other

b Balance at the end of the previous year **7b**

c Additions: (1) Contributions deposited during the year **7c(1)**

(2) Dividends and credits **7c(2)**

(3) Interest credited during the year **7c(3)**

(4) Transferred from separate account **7c(4)**

(5) Other (specify below) **7c(5)**

(6) Total additions **7c(6)**

d Total of balance and additions (add **b** and **c** (6)) **7d**

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)**

(2) Administration charge made by carrier **7e(2)**

(3) Transferred to separate account **7e(3)**

(4) Other (specify below) **7e(4)**

(5) Total deductions **7e(5)**

f Balance at the end of the current year (subtract **e**(5) from **d**) **7f**

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

a ☐ Health (other than dental or vision) **b** ☐ Dental **c** ☐ Vision **d** ☐ Life insurance

e ☐ Temporary disablility (accident and sickness) **f** ☐ Long-term disability **g** ☐ Supplemental unemployment **h** ☐ Prescription drug

i ☐ Stop loss (large deductible) **j** ☐ HMO contract **k** ☐ PPO contract **l** ☐ Indemnity contract

m ☒ Other (specify) ACCIDENTAL DEATH AND DISMEMBERMENT

9 Experience related contracts

a Premiums: (1) Amount received **9a(1)**

(2) Increase (decrease) in amount due but unpaid **9a(2)**

(3) Increase (decrease) in unearned premium reserve **9a(3)**

(4) Earned ((1)+(2)-(3)) **9a(4)**

b Benefit charges: (1) Claims paid **9b(1)**

(2) Increase (decrease) in claim reserves **9b(2)**

(3) Incurred claims (add (1) and (2)) **9b(3)**

(4) Claims charged **9b(4)**

c Remainder of premium: (1) Retention charges (on an accrual basis) –

(A) Commissions **9c(1)(A)**

(B) Administrative service or other fees **9c(1)(B)**

(C) Other specific acquisition costs **9c(1)(C)**

(D) Other expenses **9c(1)(D)**

(E) Taxes **9c(1)(E)**

(F) Charges for risks or other contingencies **9c(1)(F)**

(G) Other retention charges **9c(1)(G)**

(H) Total Retention **9c(1)(H)**

(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.) **9c(2)**

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement **9d(1)**

(2) Claim reserves **9d(2)**

(3) Other reserves **9d(3)**

e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) **9e**

10 Nonexperience-rated contracts

a Total premiums or subscription charges paid to carrier **10a** $21,152

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount **10b**

Specify nature of costs below:

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is “Yes,” specify the information not provided.

SCHEDULE A Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210 - 0110

2016

This Form is Open to Public Inspection

For the calendar plan year 2016 or fiscal plan year beginning January 01, 2016, and ending December 31, 2016

A Name of plan

FABSOUTH LLC PREMIUM CONVERSION PLAN

B Three-digit plan number (PN) 501

C Plan sponsor's name as shown on line 2a of Form 5500

FABSOUTH LLC

D Employer Identification Number (EIN) [redacted]1961

Part I · **Information Concerning Insurance Contract Coverage, Fees, and Commissions.** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information

(a) Name of insurance carrier

UNITEDHEALTHCARE INSURANCE COMPANY

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Aproximate number of persons covered at end of policy or contract year	Policy or contract year **(f)** From	**(g)** To
[redacted]9571	79413	0755852	830	01/01/2016	01/01/2016

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	**(b)** Total amount of fees paid
$518	$46

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC
1560 SAWGRASS CORP PKWY STE 300
SUNRISE FL 33323

(b) Amount of sales and base commissions paid	Fees and other commissions paid **(c)** Amount	**(d)** Purpose	**(e)** Organization code
$518	$46	SERVICE FEE AGREEMENT	3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. **Schedule A (Form 5500) 2016 v.092308.1**

Part II · **Investment and Annuity Contract Information** Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end **4**

5 Current value of plan's interest under this contract in separate accounts at year end **5**

6 Contracts With Allocated Funds

a State the basis of premium rates

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquision or retention of the contract or policy, enter amount **6d**

Specify nature of costs

e Type of contract **(1)** ☐ individual policies **(2)** ☐ group deferred annuity **(3)** ☐ other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract **(1)** ☐ deposit administration **(2)** ☐ immediate participation guarantee **(3)** ☐ guaranteed investment **(4)** ☐ other

b Balance at the end of the previous year **7b**

c Additions: (1) Contributions deposited during the year **7c(1)**

(2) Dividends and credits **7c(2)**

(3) Interest credited during the year **7c(3)**

(4) Transferred from separate account **7c(4)**

(5) Other (specify below) **7c(5)**

(6) Total additions **7c(6)**

d Total of balance and additions (add **b** and **c** (6)) **7d**

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)**

(2) Administration charge made by carrier **7e(2)**

(3) Transferred to separate account **7e(3)**

(4) Other (specify below) **7e(4)**

(5) Total deductions **7e(5)**

f Balance at the end of the current year (subtract **e**(5) from **d**) **7f**

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

a ☒ Health (other than dental or vision) **b** ☐ Dental **c** ☐ Vision **d** ☐ Life insurance

e ☐ Temporary disablility (accident and sickness) **f** ☐ Long-term disability **g** ☐ Supplemental unemployment **h** ☐ Prescription drug

i ☐ Stop loss (large deductible) **j** ☐ HMO contract **k** ☐ PPO contract **l** ☐ Indemnity contract

m ☐ Other (specify)

9 Experience related contracts

a Premiums: (1) Amount received **9a(1)**

(2) Increase (decrease) in amount due but unpaid **9a(2)**

(3) Increase (decrease) in unearned premium reserve **9a(3)**

(4) Earned ((1)+(2)-(3)) **9a(4)**

b Benefit charges: (1) Claims paid **9b(1)**

(2) Increase (decrease) in claim reserves **9b(2)**

(3) Incurred claims (add (1) and (2)) **9b(3)**

(4) Claims charged **9b(4)**

c Remainder of premium: (1) Retention charges (on an accrual basis) –

(A) Commissions **9c(1)(A)**

(B) Administrative service or other fees **9c(1)(B)**

(C) Other specific acquisition costs **9c(1)(C)**

(D) Other expenses **9c(1)(D)**

(E) Taxes **9c(1)(E)**

(F) Charges for risks or other contingencies **9c(1)(F)**

(G) Other retention charges **9c(1)(G)**

(H) Total Retention **9c(1)(H)**

(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.) **9c(2)**

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement **9d(1)**

(2) Claim reserves **9d(2)**

(3) Other reserves **9d(3)**

e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) **9e**

10 Nonexperience-rated contracts

a Total premiums or subscription charges paid to carrier **10a** $4,991

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount **10b**

Specify nature of costs below:

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is “Yes,” specify the information not provided.

SCHEDULE A Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210 - 0110

2016

This Form is Open to Public Inspection

For the calendar plan year 2016 or fiscal plan year beginning January 01, 2016, and ending December 31, 2016

A Name of plan

FABSOUTH LLC PREMIUM CONVERSION PLAN

B Three-digit plan number (PN) 501

C Plan sponsor's name as shown on line 2a of Form 5500

FABSOUTH LLC

D Employer Identification Number (EIN) [redacted]1961

Part I · **Information Concerning Insurance Contract Coverage, Fees, and Commissions.** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information

(a) Name of insurance carrier

VISION SERVICE PLAN

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Aproximate number of persons covered at end of policy or contract year	Policy or contract year **(f)** From	**(g)** To
[redacted]0825	32395	30061141	577	01/01/2016	12/31/2016

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid

(b) Total amount of fees paid

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid **(c)** Amount	**(d)** Purpose	**(e)** Organization code

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. **Schedule A (Form 5500) 2016 v.092308.1**

Part II · **Investment and Annuity Contract Information** Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end **4**

5 Current value of plan's interest under this contract in separate accounts at year end **5**

6 Contracts With Allocated Funds

a State the basis of premium rates

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquision or retention of the contract or policy, enter amount **6d**

Specify nature of costs

e Type of contract **(1)** ☐ individual policies **(2)** ☐ group deferred annuity **(3)** ☐ other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract **(1)** ☐ deposit administration **(2)** ☐ immediate participation guarantee **(3)** ☐ guaranteed investment **(4)** ☐ other

b Balance at the end of the previous year **7b**

c Additions: (1) Contributions deposited during the year **7c(1)**

(2) Dividends and credits **7c(2)**

(3) Interest credited during the year **7c(3)**

(4) Transferred from separate account **7c(4)**

(5) Other (specify below) **7c(5)**

(6) Total additions **7c(6)**

d	Total of balance and additions (add **b** and **c** (6))		**7d**
e	Deductions:		
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**	
	(2) Administration charge made by carrier	**7e(2)**	
	(3) Transferred to separate account	**7e(3)**	
	(4) Other (specify below)	**7e(4)**	
	(5) Total deductions		**7e(5)**
f	Balance at the end of the current year (subtract **e**(5) from **d**)		**7f**

Part III **Welfare Benefit Contract Information**

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

a ☐ Health (other than dental or vision)	**b** ☐ Dental	**c** ☒ Vision	**d** ☐ Life insurance
e ☐ Temporary disablility (accident and sickness)	**f** ☐ Long-term disability	**g** ☐ Supplemental unemployment	**h** ☐ Prescription drug
i ☐ Stop loss (large deductible)	**j** ☐ HMO contract	**k** ☐ PPO contract	**l** ☐ Indemnity contract
m ☐ Other (specify)			

9 Experience related contracts

a	Premiums: (1) Amount received	**9a(1)**		
	(2) Increase (decrease) in amount due but unpaid	**9a(2)**		
	(3) Increase (decrease) in unearned premium reserve	**9a(3)**		
	(4) Earned ((1)+(2)-(3))		**9a(4)**	
b	Benefit charges: (1) Claims paid	**9b(1)**		
	(2) Increase (decrease) in claim reserves	**9b(2)**		
	(3) Incurred claims (add (1) and (2))		**9b(3)**	
	(4) Claims charged		**9b(4)**	
c	Remainder of premium: (1) Retention charges (on an accrual basis) –			
	(A) Commissions	**9c(1)(A)**		
	(B) Administrative service or other fees	**9c(1)(B)**		
	(C) Other specific acquisition costs	**9c(1)(C)**		
	(D) Other expenses	**9c(1)(D)**		
	(E) Taxes	**9c(1)(E)**		
	(F) Charges for risks or other contingencies	**9c(1)(F)**		
	(G) Other retention charges	**9c(1)(G)**		
	(H) Total Retention		**9c(1)(H)**	
	(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)		**9c(2)**	
d	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		**9d(1)**	
	(2) Claim reserves		**9d(2)**	
	(3) Other reserves		**9d(3)**	
e	Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).)		**9e**	

10 Nonexperience-rated contracts

a	Total premiums or subscription charges paid to carrier	**10a**	$59,505
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount	**10b**	

Specify nature of costs below:

Part IV **Provision of Information**

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is “Yes,” specify the information not provided.

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Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

OMB Nos. 1210 - 0110
1210 - 0089

2015

This Form is Open to Public Inspection

Complete all entries in accordance with the instructions to the Form 5500.

Part I · Annual Report Identification Information

For calendar plan year 2015 or fiscal plan year beginning December 01, 2015 , and ending November 30, 2016

A a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions)for ☐ a multiemployer plan; ☐ a multiple-employer plan; ☐ a DFE (specify) ☒ a single-employer plan;

B This return/report is: ☐ the first return/report; ☐ the final return/report; ☐ an amended return/report; ☐ a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here ☐

D Check box if filling under: ☐ Form 5558; ☐ automatic extension; ☐ the DFVC program; ☐ special extension (enter description)

Part II · Basic Plan Information – enter all requested information.

1a Name of plan

ROIG LAWYERS HEALTH AND BENEFITS

1b Three-digit plan number (PN) 501

1c Effective date of plan December 01, 2000

2a Plan sponsor's name and address, including room or suite number (Employer, if for a single-employer plan)

ROIG LAWYERS
1255 SOUTH MILITARY TRAIL,
SUITE 100
DEERFIELD BEACH FL 33442

2b Employer Identification Number (EIN) [redacted]119

2c Sponsor's telephone number 954-462-0330

2d Business code (see instructions) 541110

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.
Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

	06/28/2017	MICHAEL ROSENBERG
Signature of plan administrator	Date	Enter name of individual signing as plan administrator
Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
Signature of DFE	Date	Enter name of individual signing as DFE

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. **Form 5500 (2015) v.092308.1**

3a Plan administrator's name and address (if same as plan sponsor, enter"Same")

3b Administrator's EIN

3c Administrator's telephone number

4	If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below: **a** Sponsor's name		**4b** EIN **4c** PN
5	Total number of participants at the beginning of the plan year	**5**	260
6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans only complete lines **6a(1), 6a(2), 6b, 6c,** and **6d**)		
a(1)	Total active number of participants at the beginning of the plan year	**6a(1)**	257
a(2)	Total active number of participants at the end of the plan year	**6a(2)**	
b	Retired or separated participants receiving benefits	**6b**	5
c	Other retired or separated participants entitled to future benefits	**6c**	
d	Subtotal. Add lines **6a(2), 6b,** and **6c**	**6d**	252
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**6e**	
f	Total. Add lines **6d** and **6e**	**6f**	
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	0

8a If the plan provides **pension benefits**, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:

b If the plan provides **welfare benefits**, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:

4A **4B** **4D** **4E** **4F** **4H** **4L**

9a Plan funding arrangement (check all that apply)
- **(1)** [X] Insurance
- **(2)** [ ] Section 412(e)(3) insurance contracts
- **(3)** [ ] Trust
- **(4)** [ ] General assets of the sponsor

9b Plan benefit arrangement (check all that apply)
- **(1)** [X] Insurance
- **(2)** [ ] Section 412(e)(3) insurance contracts
- **(3)** [ ] Trust
- **(4)** [ ] General assets of the sponsor

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached,and, where indicated, enter the number attached (See instructions)

a Pension Schedules
- **(1)** [ ] **R** (Retirement Plan Information)
- **(2)** [ ] **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information)- signed by the plan actuary
- **(3)** [ ] **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

b General Schedules
- **(1)** [ ] **H** (Financial Information)
- **(2)** [ ] **I** (Financial Information – Small Plan)
- **(3)** [X] 4 **A** (Insurance Information)
- **(4)** [ ] **C** (Service Provider Information)
- **(5)** [ ] **D** (DFE/Participating Plan Information)
- **(6)** [ ] **G** (Financial Transaction Schedules)

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

11a If the plan provides welfare benefits, was the plan subject to Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2)..... [ ] Yes [X] No
If "Yes" is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with M-1 filing requirements? (See instructions and 29 CFR 2520.101-2)..... [ ] Yes [ ] No

11c Enter the Receipt Confirmation Code for the 2015 Form M-1 annual report. If the plan was not required to file the 2015 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.) Receipt Confirmation Code

SCHEDULE A Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210 - 0110

2015

This Form is Open to Public Inspection

For the calendar plan year 2015 or fiscal plan year beginning December 01, 2015, and ending November 30, 2016

A Name of plan

ROIG LAWYERS HEALTH AND BENEFITS

B Three-digit plan number (PN) 501

C Plan sponsor's name as shown on line 2a of Form 5500

ROIG LAWYERS

D Employer Identification Number (EIN) [redacted]1119

Part I · **Information Concerning Insurance Contract Coverage, Fees, and Commissions.** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information

(a) Name of insurance carrier

FIDELITY SECURITY LIFE INSURANCE COMPANY

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Aproximate number of persons covered at end of policy or contract year	Policy or contract year **(f)** From	**(g)** To
[redacted]9844	71870	VARIOUS	219	12/01/2015	11/30/2016

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid: $1,809

(b) Total amount of fees paid

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC
4565 PAYPSHERE CIRCLE
CHICAGO IL 60674

(b) Amount of sales and base commissions paid	Fees and other commissions paid **(c)** Amount	**(d)** Purpose	**(e)** Organization code
$1,809			3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. **Schedule A (Form 5500) 2015 v.092308.1**

Part II · **Investment and Annuity Contract Information** Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end **4**

5 Current value of plan's interest under this contract in separate accounts at year end **5**

6 Contracts With Allocated Funds

a State the basis of premium rates

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquision or retention of the contract or policy, enter amount **6d**

Specify nature of costs

e Type of contract **(1)** ☐ individual policies **(2)** ☐ group deferred annuity **(3)** ☐ other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract **(1)** ☐ deposit administration **(2)** ☐ immediate participation guarantee **(3)** ☐ guaranteed investment **(4)** ☐ other

b Balance at the end of the previous year **7b**

c Additions: (1) Contributions deposited during the year **7c(1)**

(2) Dividends and credits **7c(2)**

(3) Interest credited during the year **7c(3)**

(4) Transferred from separate account **7c(4)**

(5) Other (specify below) **7c(5)**

(6) Total additions **7c(6)**

d Total of balance and additions (add **b** and **c** (6)) **7d**

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)**

(2) Administration charge made by carrier **7e(2)**

(3) Transferred to separate account **7e(3)**

(4) Other (specify below) **7e(4)**

(5) Total deductions **7e(5)**

f Balance at the end of the current year (subtract **e**(5) from **d**) **7f**

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

a ☐ Health (other than dental or vision) **b** ☐ Dental **c** ☒ Vision **d** ☐ Life insurance

e ☐ Temporary disablility (accident and sickness) **f** ☐ Long-term disability **g** ☐ Supplemental unemployment **h** ☐ Prescription drug

i ☐ Stop loss (large deductible) **j** ☐ HMO contract **k** ☐ PPO contract **l** ☐ Indemnity contract

m ☐ Other (specify)

9 Experience related contracts

a Premiums: (1) Amount received **9a(1)**

(2) Increase (decrease) in amount due but unpaid **9a(2)**

(3) Increase (decrease) in unearned premium reserve **9a(3)**

(4) Earned ((1)+(2)-(3)) **9a(4)**

b Benefit charges: (1) Claims paid **9b(1)**

(2) Increase (decrease) in claim reserves **9b(2)**

(3) Incurred claims (add (1) and (2)) **9b(3)**

(4) Claims charged **9b(4)**

c Remainder of premium: (1) Retention charges (on an accrual basis) –

(A) Commissions **9c(1)(A)**

(B) Administrative service or other fees **9c(1)(B)**

(C) Other specific acquisition costs **9c(1)(C)**

(D) Other expenses **9c(1)(D)**

(E) Taxes **9c(1)(E)**

(F) Charges for risks or other contingencies **9c(1)(F)**

(G) Other retention charges **9c(1)(G)**

(H) Total Retention **9c(1)(H)**

(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.) **9c(2)**

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement **9d(1)**

(2) Claim reserves **9d(2)**

(3) Other reserves **9d(3)**

e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) **9e**

10 Nonexperience-rated contracts

a Total premiums or subscription charges paid to carrier **10a** $18,004

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount **10b**

Specify nature of costs below:

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is “Yes,” specify the information not provided.

SCHEDULE A Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210 - 0110

2015

This Form is Open to Public Inspection

For the calendar plan year 2015 or fiscal plan year beginning December 01, 2015, and ending November 30, 2016

A Name of plan

ROIG LAWYERS HEALTH AND BENEFITS

B Three-digit plan number (PN) 501

C Plan sponsor's name as shown on line 2a of Form 5500

ROIG LAWYERS

D Employer Identification Number (EIN) [redacted]1119

Part I · **Information Concerning Insurance Contract Coverage, Fees, and Commissions.** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information

(a) Name of insurance carrier

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Aproximate number of persons covered at end of policy or contract year	Policy or contract year (f) From	(g) To
[redacted]3390	64246	00505636	200	12/01/2015	11/30/2016

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
$11,033	$1,027

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC
ONE INVESTORS WAY
NORWOOD MA 02062

(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount	(d) Purpose	(e) Organization code
$11,033	$1,027	FEES	3

Part II · **Investment and Annuity Contract Information**

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end — **4**

5 Current value of plan's interest under this contract in separate accounts at year end — **5**

6 Contracts With Allocated Funds

a State the basis of premium rates

b Premiums paid to carrier — **6b**

c Premiums due but unpaid at the end of the year — **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquision or retention of the contract or policy, enter amount — **6d**

Specify nature of costs

e Type of contract **(1)** ☐ individual policies **(2)** ☐ group deferred annuity **(3)** ☐ other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract **(1)** ☐ deposit administration **(2)** ☐ immediate participation guarantee **(3)** ☐ guaranteed investment **(4)** ☐ other

b Balance at the end of the previous year — **7b**

c Additions: (1) Contributions deposited during the year — **7c(1)**

(2) Dividends and credits — **7c(2)**

(3) Interest credited during the year — **7c(3)**

(4) Transferred from separate account — **7c(4)**

(5) Other (specify below)	7c(5)		
(6) Total additions		7c(6)	
d Total of balance and additions (add **b** and **c** (6))		7d	
e Deductions:			
(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
(2) Administration charge made by carrier	7e(2)		
(3) Transferred to separate account	7e(3)		
(4) Other (specify below)	7e(4)		
(5) Total deductions		7e(5)	
f Balance at the end of the current year (subtract **e**(5) from **d**)		7f	

Part III **Welfare Benefit Contract Information**

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

a ☐ Health (other than dental or vision)	**b** ☒ Dental	**c** ☐ Vision	**d** ☐ Life insurance
e ☐ Temporary disablility (accident and sickness)	**f** ☐ Long-term disability	**g** ☐ Supplemental unemployment	**h** ☐ Prescription drug
i ☐ Stop loss (large deductible)	**j** ☐ HMO contract	**k** ☐ PPO contract	**l** ☐ Indemnity contract
m ☐ Other (specify)			

9 Experience related contracts

a Premiums: (1) Amount received	9a(1)		
(2) Increase (decrease) in amount due but unpaid	9a(2)		
(3) Increase (decrease) in unearned premium reserve	9a(3)		
(4) Earned ((1)+(2)-(3))		9a(4)	
b Benefit charges: (1) Claims paid	9b(1)		
(2) Increase (decrease) in claim reserves	9b(2)		
(3) Incurred claims (add (1) and (2))		9b(3)	
(4) Claims charged		9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) –			
(A) Commissions	9c(1)(A)		
(B) Administrative service or other fees	9c(1)(B)		
(C) Other specific acquisition costs	9c(1)(C)		
(D) Other expenses	9c(1)(D)		
(E) Taxes	9c(1)(E)		
(F) Charges for risks or other contingencies	9c(1)(F)		
(G) Other retention charges	9c(1)(G)		
(H) Total Retention		9c(1)(H)	
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)		9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		9d(1)	
(2) Claim reserves		9d(2)	
(3) Other reserves		9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).)		9e	

10 Nonexperience-rated contracts

a Total premiums or subscription charges paid to carrier	10a	$110,330
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount	10b	

Specify nature of costs below:

Part IV **Provision of Information**

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is “Yes,” specify the information not provided.

SCHEDULE A Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210 - 0110

2015

This Form is Open to Public Inspection

For the calendar plan year 2015 or fiscal plan year beginning December 01, 2015, and ending November 30, 2016

A Name of plan

ROIG LAWYERS HEALTH AND BENEFITS

B Three-digit plan number (PN) 501

C Plan sponsor's name as shown on line 2a of Form 5500

ROIG LAWYERS

D Employer Identification Number (EIN) [redacted]1119

Part I · **Information Concerning Insurance Contract Coverage, Fees, and Commissions.** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information

(a) Name of insurance carrier

SUN LIFE ASSURANCE COMPANY OF CANADA

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Aproximate number of persons covered at end of policy or contract year	Policy or contract year **(f)** From	**(g)** To
[redacted]2080	80802	238423	248	12/01/2015	11/30/2016

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid: $18,744

(b) Total amount of fees paid:

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC
4565 PAYSPHERE CIRCLE
CHICAGO IL 60674

(b) Amount of sales and base commissions paid	Fees and other commissions paid **(c)** Amount	**(d)** Purpose	**(e)** Organization code
$18,744			3

Part II · **Investment and Annuity Contract Information**

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end **4**

5 Current value of plan's interest under this contract in separate accounts at year end **5**

6 Contracts With Allocated Funds

a State the basis of premium rates

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquision or retention of the contract or policy, enter amount **6d**

Specify nature of costs

e Type of contract **(1)** ☐ individual policies **(2)** ☐ group deferred annuity **(3)** ☐ other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract **(1)** ☐ deposit administration **(2)** ☐ immediate participation guarantee **(3)** ☐ guaranteed investment **(4)** ☐ other

b Balance at the end of the previous year **7b**

c Additions: (1) Contributions deposited during the year **7c(1)**

(2) Dividends and credits **7c(2)**

(3) Interest credited during the year **7c(3)**

(4) Transferred from separate account **7c(4)**

(5) Other (specify below) **7c(5)**

(6) Total additions **7c(6)**

d Total of balance and additions (add **b** and **c** (6)) **7d**

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)**

(2) Administration charge made by carrier **7e(2)**

(3) Transferred to separate account **7e(3)**

(4) Other (specify below) **7e(4)**

(5) Total deductions **7e(5)**

f Balance at the end of the current year (subtract **e**(5) from **d**) **7f**

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

a ☐ Health (other than dental or vision) **b** ☐ Dental **c** ☐ Vision **d** ☒ Life insurance

e ☒ Temporary disablility (accident and sickness) **f** ☒ Long-term disability **g** ☐ Supplemental unemployment **h** ☐ Prescription drug

i ☐ Stop loss (large deductible) **j** ☐ HMO contract **k** ☐ PPO contract **l** ☐ Indemnity contract

m ☒ Other (specify) ACCIDENTAL DEATH AND DISMEMBERMENT

9 Experience related contracts

a Premiums: (1) Amount received **9a(1)**

(2) Increase (decrease) in amount due but unpaid **9a(2)**

(3) Increase (decrease) in unearned premium reserve **9a(3)**

(4) Earned ((1)+(2)-(3)) **9a(4)**

b Benefit charges: (1) Claims paid **9b(1)**

(2) Increase (decrease) in claim reserves **9b(2)**

(3) Incurred claims (add (1) and (2)) **9b(3)**

(4) Claims charged **9b(4)**

c Remainder of premium: (1) Retention charges (on an accrual basis) –

(A) Commissions **9c(1)(A)**

(B) Administrative service or other fees **9c(1)(B)**

(C) Other specific acquisition costs **9c(1)(C)**

(D) Other expenses **9c(1)(D)**

(E) Taxes **9c(1)(E)**

(F) Charges for risks or other contingencies **9c(1)(F)**

(G) Other retention charges **9c(1)(G)**

(H) Total Retention **9c(1)(H)**

(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.) **9c(2)**

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement **9d(1)**

(2) Claim reserves **9d(2)**

(3) Other reserves **9d(3)**

e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) **9e**

10 Nonexperience-rated contracts

a Total premiums or subscription charges paid to carrier **10a** $125,004

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount **10b**

Specify nature of costs below:

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is “Yes,” specify the information not provided.

SCHEDULE A Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210 - 0110

2015

This Form is Open to Public Inspection

For the calendar plan year 2015 or fiscal plan year beginning December 01, 2015, and ending November 30, 2016

A Name of plan

ROIG LAWYERS HEALTH AND BENEFITS

B Three-digit plan number (PN) 501

C Plan sponsor's name as shown on line 2a of Form 5500

ROIG LAWYERS

D Employer Identification Number (EIN) [redacted]1119

Part I · **Information Concerning Insurance Contract Coverage, Fees, and Commissions.** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information

(a) Name of insurance carrier

UNITEDHEALTHCARE INSURANCE COMPANY

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Aproximate number of persons covered at end of policy or contract year	Policy or contract year **(f)** From	**(g)** To
[redacted]9571	79413	903798	272	12/01/2015	11/30/2016

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid

(b) Total amount of fees paid

$78,805

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC
1560 SAWGRASS CORPORATE PKWY #300
SUNRISE FL 33323

(b) Amount of sales and base commissions paid	Fees and other commissions paid **(c)** Amount	**(d)** Purpose	**(e)** Organization code
	$78,805	SERVICE FEE AGREEMENT	3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. **Schedule A (Form 5500) 2015 v.092308.1**

Part II · **Investment and Annuity Contract Information**

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end **4**

5 Current value of plan's interest under this contract in separate accounts at year end **5**

6 Contracts With Allocated Funds

a State the basis of premium rates

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquision or retention of the contract or policy, enter amount **6d**

Specify nature of costs

e Type of contract **(1)** ☐ individual policies **(2)** ☐ group deferred annuity **(3)** ☐ other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract **(1)** ☐ deposit administration **(2)** ☐ immediate participation guarantee **(3)** ☐ guaranteed investment **(4)** ☐ other

b Balance at the end of the previous year **7b**

c Additions: (1) Contributions deposited during the year **7c(1)**

(2) Dividends and credits **7c(2)**

(3) Interest credited during the year **7c(3)**

(4) Transferred from separate account **7c(4)**

(5) Other (specify below)	7c(5)		
(6) Total additions		7c(6)	
d Total of balance and additions (add **b** and **c** (6))		7d	
e Deductions:			
(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
(2) Administration charge made by carrier	7e(2)		
(3) Transferred to separate account	7e(3)		
(4) Other (specify below)	7e(4)		
(5) Total deductions		7e(5)	
f Balance at the end of the current year (subtract **e**(5) from **d**)		7f	

Part III **Welfare Benefit Contract Information**

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

a ☒ Health (other than dental or vision)	**b** ☐ Dental	**c** ☐ Vision	**d** ☐ Life insurance
e ☐ Temporary disablility (accident and sickness)	**f** ☐ Long-term disability	**g** ☐ Supplemental unemployment	**h** ☒ Prescription drug
i ☐ Stop loss (large deductible)	**j** ☐ HMO contract	**k** ☐ PPO contract	**l** ☐ Indemnity contract
m ☐ Other (specify)			

9 Experience related contracts

a Premiums: (1) Amount received	9a(1)		
(2) Increase (decrease) in amount due but unpaid	9a(2)		
(3) Increase (decrease) in unearned premium reserve	9a(3)		
(4) Earned ((1)+(2)-(3))		9a(4)	
b Benefit charges: (1) Claims paid	9b(1)		
(2) Increase (decrease) in claim reserves	9b(2)		
(3) Incurred claims (add (1) and (2))		9b(3)	
(4) Claims charged		9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) –			
(A) Commissions	9c(1)(A)		
(B) Administrative service or other fees	9c(1)(B)		
(C) Other specific acquisition costs	9c(1)(C)		
(D) Other expenses	9c(1)(D)		
(E) Taxes	9c(1)(E)		
(F) Charges for risks or other contingencies	9c(1)(F)		
(G) Other retention charges	9c(1)(G)		
(H) Total Retention		9c(1)(H)	
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)		9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		9d(1)	
(2) Claim reserves		9d(2)	
(3) Other reserves		9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).)		9e	

10 Nonexperience-rated contracts

a Total premiums or subscription charges paid to carrier	10a	$1,498,203
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount	10b	

Specify nature of costs below:

Part IV **Provision of Information**

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is “Yes,” specify the information not provided.

freeERISA.com

Form 5500

Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

OMB Nos. 1210 - 0110
1210 - 0089

2016

This Form is Open to Public Inspection

Complete all entries in accordance with the instructions to the Form 5500.

Part I · Annual Report Identification Information

For calendar plan year 2016 or fiscal plan year beginning March 01, 2016 , and ending February 28, 2017

A a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions)for ☐ a multiemployer plan; ☐ a multiple-employer plan; ☐ a DFE (specify) ☒ a single-employer plan;

B This return/report is: ☐ the first return/report; ☐ the final return/report; ☐ an amended return/report; ☐ a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here ☐

D Check box if filling under: ☐ Form 5558; ☐ automatic extension; ☐ the DFVC program; ☐ special extension (enter description)

Part II · Basic Plan Information – enter all requested information.

1a Name of plan

VISION GROUP HOLDINGS HEALTH & WELFARE BENEFITS

1b Three-digit plan number (PN) 501

1c Effective date of plan March 01, 2015

2a Plan sponsor's name and address, including room or suite number (Employer, if for a single-employer plan)

VISION GROUP HOLDINGS
1555 PALM BEACH LAKES BOULEVARD
SUITE 600
WEST PALM BEACH FL 33401

2b Employer Identification Number (EIN) [redacted]7674

2c Sponsor's telephone number 561-965-9110

2d Business code (see instructions) 446130

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.
Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

	09/21/2017	SHARON L. WAY
Signature of plan administrator	Date	Enter name of individual signing as plan administrator
Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
Signature of DFE	Date	Enter name of individual signing as DFE

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. **Form 5500 (2016) v.092308.1**

3a Plan administrator's name and address (if same as plan sponsor, enter"Same")

3b Administrator's EIN

3c Administrator's telephone number

4	If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below: **a** Sponsor's name VISION GROUP HOLDINGS, LLC		**4b** EIN 51-0487674 **4c** PN 501
5	Total number of participants at the beginning of the plan year	**5**	839
6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans only complete lines **6a(1), 6a(2), 6b, 6c,** and **6d**)		
a(1)	Total active number of participants at the beginning of the plan year	**6a(1)**	512
a(2)	Total active number of participants at the end of the plan year	**6a(2)**	
b	Retired or separated participants receiving benefits	**6b**	
c	Other retired or separated participants entitled to future benefits	**6c**	
d	Subtotal. Add lines **6a(2), 6b,** and **6c**	**6d**	611
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**6e**	
f	Total. Add lines **6d** and **6e**	**6f**	
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	0

8a If the plan provides **pension benefits**, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:

b If the plan provides **welfare benefits**, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:

4A 4B 4D 4E 4F 4H 4L 4Q

9a Plan funding arrangement (check all that apply)
- **(1)** [X] Insurance
- **(2)** [ ] Section 412(e)(3) insurance contracts
- **(3)** [ ] Trust
- **(4)** [X] General assets of the sponsor

9b Plan benefit arrangement (check all that apply)
- **(1)** [X] Insurance
- **(2)** [ ] Section 412(e)(3) insurance contracts
- **(3)** [ ] Trust
- **(4)** [X] General assets of the sponsor

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached,and, where indicated, enter the number attached (See instructions)

a Pension Schedules
- **(1)** [ ] **R** (Retirement Plan Information)
- **(2)** [ ] **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information)- signed by the plan actuary
- **(3)** [ ] **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

b General Schedules
- **(1)** [ ] **H** (Financial Information)
- **(2)** [ ] **I** (Financial Information – Small Plan)
- **(3)** [X] 3 **A** (Insurance Information)
- **(4)** [ ] **C** (Service Provider Information)
- **(5)** [ ] **D** (DFE/Participating Plan Information)
- **(6)** [ ] **G** (Financial Transaction Schedules)

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

11a If the plan provides welfare benefits, was the plan subject to Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2)..... [ ] Yes [X] No
If "Yes" is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with M-1 filing requirements? (See instructions and 29 CFR 2520.101-2)..... [ ] Yes [ ] No

11c Enter the Receipt Confirmation Code for the 2016 Form M-1 annual report. If the plan was not required to file the 2016 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.) Receipt Confirmation Code

SCHEDULE A Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210 - 0110

2016

This Form is Open to Public Inspection

For the calendar plan year 2016 or fiscal plan year beginning March 01, 2016, and ending February 28, 2017

A Name of plan

VISION GROUP HOLDINGS HEALTH & WELFARE BENEFITS

B Three-digit plan number (PN) 501

C Plan sponsor's name as shown on line 2a of Form 5500

VISION GROUP HOLDINGS

D Employer Identification Number (EIN) [redacted]7674

Part I · **Information Concerning Insurance Contract Coverage, Fees, and Commissions.** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information

(a) Name of insurance carrier

METROPOLITAN LIFE INSURANCE COMPANY

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Aproximate number of persons covered at end of policy or contract year	Policy or contract year **(f)** From	**(g)** To
[redacted]1829	65978	5926235	1623	03/01/2016	02/28/2017

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	**(b)** Total amount of fees paid
$39,849	$5,653

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

WELLS FARGO INSURANCE
1018 WEST 9TH AVENUE
KING OF PRUSSIA PA 19406

(b) Amount of sales and base commissions paid	Fees and other commissions paid **(c)** Amount	**(d)** Purpose	**(e)** Organization code
$39,849	$5,653	NON-MONETARY COMPENSATION SUPPLEMENTAL COMPENSATION	3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. **Schedule A (Form 5500) 2016 v.092308.1**

Part II · **Investment and Annuity Contract Information**

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end **4**

5 Current value of plan's interest under this contract in separate accounts at year end **5**

6 Contracts With Allocated Funds

a State the basis of premium rates

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquision or retention of the contract or policy, enter amount **6d**

Specify nature of costs

e Type of contract **(1)** ☐ individual policies **(2)** ☐ group deferred annuity **(3)** ☐ other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract **(1)** ☐ deposit administration **(2)** ☐ immediate participation guarantee **(3)** ☐ guaranteed investment **(4)** ☐ other

b Balance at the end of the previous year **7b**

c Additions: (1) Contributions deposited during the year **7c(1)**

(2) Dividends and credits **7c(2)**

(3) Interest credited during the year **7c(3)**

(4) Transferred from separate account **7c(4)**

(5) Other (specify below) **7c(5)**

(6) Total additions **7c(6)**

d Total of balance and additions (add **b** and **c** (6)) **7d**

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)**

(2) Administration charge made by carrier **7e(2)**

(3) Transferred to separate account **7e(3)**

(4) Other (specify below) **7e(4)**

(5) Total deductions **7e(5)**

f Balance at the end of the current year (subtract **e**(5) from **d**) **7f**

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

a ☐ Health (other than dental or vision) **b** ☒ Dental **c** ☒ Vision **d** ☐ Life insurance

e ☐ Temporary disablility (accident and sickness) **f** ☐ Long-term disability **g** ☐ Supplemental unemployment **h** ☐ Prescription drug

i ☐ Stop loss (large deductible) **j** ☐ HMO contract **k** ☐ PPO contract **l** ☐ Indemnity contract

m ☐ Other (specify)

9 Experience related contracts

a Premiums: (1) Amount received **9a(1)**

(2) Increase (decrease) in amount due but unpaid **9a(2)**

(3) Increase (decrease) in unearned premium reserve **9a(3)**

(4) Earned ((1)+(2)-(3)) **9a(4)**

b Benefit charges: (1) Claims paid **9b(1)**

(2) Increase (decrease) in claim reserves **9b(2)**

(3) Incurred claims (add (1) and (2)) **9b(3)**

(4) Claims charged **9b(4)**

c Remainder of premium: (1) Retention charges (on an accrual basis) –

(A) Commissions **9c(1)(A)**

(B) Administrative service or other fees **9c(1)(B)**

(C) Other specific acquisition costs **9c(1)(C)**

(D) Other expenses **9c(1)(D)**

(E) Taxes **9c(1)(E)**

(F) Charges for risks or other contingencies **9c(1)(F)**

(G) Other retention charges **9c(1)(G)**

(H) Total Retention **9c(1)(H)**

(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.) **9c(2)**

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement **9d(1)**

(2) Claim reserves **9d(2)**

(3) Other reserves **9d(3)**

e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) **9e**

10 Nonexperience-rated contracts

a Total premiums or subscription charges paid to carrier **10a** $406,117

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount **10b**

Specify nature of costs below:

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is “Yes,” specify the information not provided.

SCHEDULE A Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210 - 0110

2016

This Form is Open to Public Inspection

For the calendar plan year 2016 or fiscal plan year beginning March 01, 2016, and ending February 28, 2017

A Name of plan

VISION GROUP HOLDINGS HEALTH & WELFARE BENEFITS

B Three-digit plan number (PN) 501

C Plan sponsor's name as shown on line 2a of Form 5500

VISION GROUP HOLDINGS

D Employer Identification Number (EIN) [redacted]7674

Part I · **Information Concerning Insurance Contract Coverage, Fees, and Commissions.** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information

(a) Name of insurance carrier

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Aproximate number of persons covered at end of policy or contract year	Policy or contract year (f) From	(g) To
[redacted]300	65676	10203096	925	03/01/2016	02/28/2017

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
$32,729	$10,454

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

WELLS FARGO INSURANCE
2502 NORTH ROCKY POINT DRIVE 400
ROCKY POINT FL 33607

(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount	(d) Purpose	(e) Organization code
$32,729	$10,454	FEES	3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. **Schedule A (Form 5500) 2016 v.092308.1**

Part II · **Investment and Annuity Contract Information** Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end **4**

5 Current value of plan's interest under this contract in separate accounts at year end **5**

6 Contracts With Allocated Funds

a State the basis of premium rates

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquision or retention of the contract or policy, enter amount **6d**

Specify nature of costs

e Type of contract **(1)** ☐ individual policies **(2)** ☐ group deferred annuity **(3)** ☐ other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract **(1)** ☐ deposit administration **(2)** ☐ immediate participation guarantee **(3)** ☐ guaranteed investment **(4)** ☐ other

b Balance at the end of the previous year **7b**

c Additions: (1) Contributions deposited during the year **7c(1)**

(2) Dividends and credits **7c(2)**

(3) Interest credited during the year **7c(3)**

(4) Transferred from separate account **7c(4)**

(5) Other (specify below) **7c(5)**

(6) Total additions **7c(6)**

d Total of balance and additions (add **b** and **c** (6)) **7d**

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)**

(2) Administration charge made by carrier **7e(2)**

(3) Transferred to separate account **7e(3)**

(4) Other (specify below) **7e(4)**

(5) Total deductions **7e(5)**

f Balance at the end of the current year (subtract **e**(5) from **d**) **7f**

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

a ☐ Health (other than dental or vision) **b** ☐ Dental **c** ☐ Vision **d** ☒ Life insurance

e ☒ Temporary disablility (accident and sickness) **f** ☒ Long-term disability **g** ☐ Supplemental unemployment **h** ☐ Prescription drug

i ☐ Stop loss (large deductible) **j** ☐ HMO contract **k** ☐ PPO contract **l** ☐ Indemnity contract

m ☒ Other (specify) ACCIDENTAL DEATH AND DISMEMBERMENT EMPLOYEE ASSISTANCE PROGRAM

9 Experience related contracts

a Premiums: (1) Amount received **9a(1)**

(2) Increase (decrease) in amount due but unpaid **9a(2)**

(3) Increase (decrease) in unearned premium reserve **9a(3)**

(4) Earned ((1)+(2)-(3)) **9a(4)**

b Benefit charges: (1) Claims paid **9b(1)**

(2) Increase (decrease) in claim reserves **9b(2)**

(3) Incurred claims (add (1) and (2)) **9b(3)**

(4) Claims charged **9b(4)**

c Remainder of premium: (1) Retention charges (on an accrual basis) –

(A) Commissions **9c(1)(A)**

(B) Administrative service or other fees **9c(1)(B)**

(C) Other specific acquisition costs **9c(1)(C)**

(D) Other expenses **9c(1)(D)**

(E) Taxes **9c(1)(E)**

(F) Charges for risks or other contingencies **9c(1)(F)**

(G) Other retention charges **9c(1)(G)**

(H) Total Retention **9c(1)(H)**

(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.) **9c(2)**

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement **9d(1)**

(2) Claim reserves **9d(2)**

(3) Other reserves **9d(3)**

e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) **9e**

10 Nonexperience-rated contracts

a Total premiums or subscription charges paid to carrier **10a** $327,286

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount **10b**

Specify nature of costs below:

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is “Yes,” specify the information not provided.

SCHEDULE A Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210 - 0110

2016

This Form is Open to Public Inspection

For the calendar plan year 2016 or fiscal plan year beginning March 01, 2016, and ending February 28, 2017

A Name of plan

VISION GROUP HOLDINGS HEALTH & WELFARE BENEFITS

B Three-digit plan number (PN) 501

C Plan sponsor's name as shown on line 2a of Form 5500

VISION GROUP HOLDINGS

D Employer Identification Number (EIN) [redacted]7674

Part I · **Information Concerning Insurance Contract Coverage, Fees, and Commissions.** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information

(a) Name of insurance carrier

AMERICAN HERITAGE LIFE INSURANCE COMPANY

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Aproximate number of persons covered at end of policy or contract year	Policy or contract year **(f)** From	**(g)** To
[redacted]1901	60534	V7880	80	03/01/2016	02/28/2017

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid: $4,875

(b) Total amount of fees paid:

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

WELLS FARGO INSURANCE
PO BOX 201629
DALLAS TX 75320

(b) Amount of sales and base commissions paid	Fees and other commissions paid **(c)** Amount	**(d)** Purpose	**(e)** Organization code
$4,875			3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. **Schedule A (Form 5500) 2016 v.092308.1**

Part II · **Investment and Annuity Contract Information** Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end **4**

5 Current value of plan's interest under this contract in separate accounts at year end **5**

6 Contracts With Allocated Funds

a State the basis of premium rates

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquision or retention of the contract or policy, enter amount **6d**

Specify nature of costs

e Type of contract **(1)** ☐ individual policies **(2)** ☐ group deferred annuity **(3)** ☐ other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract **(1)** ☐ deposit administration **(2)** ☐ immediate participation guarantee **(3)** ☐ guaranteed investment **(4)** ☐ other

b Balance at the end of the previous year **7b**

c Additions: (1) Contributions deposited during the year **7c(1)**

(2) Dividends and credits **7c(2)**

(3) Interest credited during the year **7c(3)**

(4) Transferred from separate account **7c(4)**

(5) Other (specify below) **7c(5)**

(6) Total additions **7c(6)**

d Total of balance and additions (add **b** and **c** (6)) **7d**

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)**

(2) Administration charge made by carrier **7e(2)**

(3) Transferred to separate account **7e(3)**

(4) Other (specify below) **7e(4)**

(5) Total deductions **7e(5)**

f Balance at the end of the current year (subtract **e**(5) from **d**) **7f**

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

a ☒ Health (other than dental or vision) **b** ☐ Dental **c** ☐ Vision **d** ☐ Life insurance

e ☐ Temporary disablility (accident and sickness) **f** ☐ Long-term disability **g** ☐ Supplemental unemployment **h** ☐ Prescription drug

i ☐ Stop loss (large deductible) **j** ☐ HMO contract **k** ☐ PPO contract **l** ☐ Indemnity contract

m ☒ Other (specify) CRITICAL ILLNESS ACCIDENT

9 Experience related contracts

a Premiums: (1) Amount received **9a(1)**

(2) Increase (decrease) in amount due but unpaid **9a(2)**

(3) Increase (decrease) in unearned premium reserve **9a(3)**

(4) Earned ((1)+(2)-(3)) **9a(4)**

b Benefit charges: (1) Claims paid **9b(1)**

(2) Increase (decrease) in claim reserves **9b(2)**

(3) Incurred claims (add (1) and (2)) **9b(3)**

(4) Claims charged **9b(4)**

c Remainder of premium: (1) Retention charges (on an accrual basis) –

(A) Commissions **9c(1)(A)**

(B) Administrative service or other fees **9c(1)(B)**

(C) Other specific acquisition costs **9c(1)(C)**

(D) Other expenses **9c(1)(D)**

(E) Taxes **9c(1)(E)**

(F) Charges for risks or other contingencies **9c(1)(F)**

(G) Other retention charges **9c(1)(G)**

(H) Total Retention **9c(1)(H)**

(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.) **9c(2)**

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement **9d(1)**

(2) Claim reserves **9d(2)**

(3) Other reserves **9d(3)**

e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) **9e**

10 Nonexperience-rated contracts

a Total premiums or subscription charges paid to carrier **10a** $25,607

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount **10b**

Specify nature of costs below:

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is “Yes,” specify the information not provided.

freeERISA.com

Form 5500

Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

OMB Nos. 1210 - 0110
1210 - 0089

2016

This Form is Open to Public Inspection

Complete all entries in accordance with the instructions to the Form 5500.

Part I · Annual Report Identification Information

For calendar plan year 2016 or fiscal plan year beginning January 01, 2016 , and ending December 31, 2016

A a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions)for ☐ a multiemployer plan; ☐ a multiple-employer plan; ☐ a DFE (specify) ☒ a single-employer plan;

B This return/report is: ☐ the first return/report; ☐ the final return/report; ☐ an amended return/report; ☐ a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here ☐

D Check box if filling under: ☒ Form 5558; ☐ automatic extension; ☐ the DFVC program; ☐ special extension (enter description)

Part II · Basic Plan Information – enter all requested information.

1a Name of plan

INTERCONTINENTAL AT DORAL MIAMI HEALTH AND WELFARE PLAN

1b Three-digit plan number (PN) 501

1c Effective date of plan May 01, 2000

2a Plan sponsor's name and address, including room or suite number (Employer, if for a single-employer plan)

INTERCONTINENTAL AT DORAL MIAMI
2505 NW 87TH AVE
DORAL FL 33172

2b Employer Identification Number (EIN) [redacted]2710

2c Sponsor's telephone number 305-468-1400

2d Business code (see instructions) 531390

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.
Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

Signature of plan administrator	09/08/2017 Date	ROSIE BALLESTER Enter name of individual signing as plan administrator
Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
Signature of DFE	Date	Enter name of individual signing as DFE

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. **Form 5500 (2016) v.092308.1**

3a Plan administrator's name and address (if same as plan sponsor, enter"Same")

3b Administrator's EIN

3c Administrator's telephone number

4	If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below: **a** Sponsor's name		**4b** EIN **4c** PN
5	Total number of participants at the beginning of the plan year	**5**	169
6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans only complete lines **6a(1), 6a(2), 6b, 6c,** and **6d**)		
a(1)	Total active number of participants at the beginning of the plan year	**6a(1)**	168
a(2)	Total active number of participants at the end of the plan year	**6a(2)**	
b	Retired or separated participants receiving benefits	**6b**	
c	Other retired or separated participants entitled to future benefits	**6c**	
d	Subtotal. Add lines **6a(2), 6b,** and **6c**	**6d**	171
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**6e**	
f	Total. Add lines **6d** and **6e**	**6f**	
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	0

8a If the plan provides **pension benefits**, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:

b If the plan provides **welfare benefits**, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:

4A **4B** **4D** **4E** **4F** **4G** **4H** **4L**

9a Plan funding arrangement (check all that apply)
- **(1)** ☒ Insurance
- **(2)** ☐ Section 412(e)(3) insurance contracts
- **(3)** ☐ Trust
- **(4)** ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)
- **(1)** ☒ Insurance
- **(2)** ☐ Section 412(e)(3) insurance contracts
- **(3)** ☐ Trust
- **(4)** ☐ General assets of the sponsor

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached,and, where indicated, enter the number attached (See instructions)

a Pension Schedules
- **(1)** ☐ **R** (Retirement Plan Information)
- **(2)** ☐ **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information)- signed by the plan actuary
- **(3)** ☐ **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

b General Schedules
- **(1)** ☐ **H** (Financial Information)
- **(2)** ☐ **I** (Financial Information – Small Plan)
- **(3)** ☒ 10 **A** (Insurance Information)
- **(4)** ☐ **C** (Service Provider Information)
- **(5)** ☐ **D** (DFE/Participating Plan Information)
- **(6)** ☐ **G** (Financial Transaction Schedules)

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

11a If the plan provides welfare benefits, was the plan subject to Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2)..... ☐ Yes ☒ No
If "Yes" is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with M-1 filing requirements? (See instructions and 29 CFR 2520.101-2)..... ☐ Yes ☐ No

11c Enter the Receipt Confirmation Code for the 2016 Form M-1 annual report. If the plan was not required to file the 2016 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.) Receipt Confirmation Code

SCHEDULE A Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210 - 0110

2016

This Form is Open to Public Inspection

For the calendar plan year 2016 or fiscal plan year beginning January 01, 2016, and ending December 31, 2016

A Name of plan

INTERCONTINENTAL AT DORAL MIAMI HEALTH AND WELFARE PLAN

B Three-digit plan number (PN) 501

C Plan sponsor's name as shown on line 2a of Form 5500

INTERCONTINENTAL AT DORAL MIAMI

D Employer Identification Number (EIN) [redacted]2710

Part I · **Information Concerning Insurance Contract Coverage, Fees, and Commissions.** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information

(a) Name of insurance carrier

AFLAC

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Aproximate number of persons covered at end of policy or contract year	Policy or contract year **(f)** From	**(g)** To
[redacted]3085	60380	CG420	11	01/01/2016	12/31/2016

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid: $972

(b) Total amount of fees paid:

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

VARIOUS-SEE ATTACHMENT
1932 WYNNTON ROAD
COLUMBUS GA 31999

(b) Amount of sales and base commissions paid	Fees and other commissions paid **(c)** Amount	**(d)** Purpose	**(e)** Organization code
$972			3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. **Schedule A (Form 5500) 2016 v.092308.1**

Part II · **Investment and Annuity Contract Information** Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	**4**
5	Current value of plan's interest under this contract in separate accounts at year end	**5**
6	Contracts With Allocated Funds	
a	State the basis of premium rates	
b	Premiums paid to carrier	**6b**
c	Premiums due but unpaid at the end of the year	**6c**
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquision or retention of the contract or policy, enter amount Specify nature of costs	**6d**
e	Type of contract **(1)** ☐ individual policies **(2)** ☐ group deferred annuity **(3)** ☐ other (specify)	
f	If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ☐	
7	Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)	
a	Type of contract **(1)** ☐ deposit administration **(2)** ☐ immediate participation guarantee **(3)** ☐ guaranteed investment **(4)** ☐ other	
b	Balance at the end of the previous year	**7b**
c	Additions: (1) Contributions deposited during the year	**7c(1)**
	(2) Dividends and credits	**7c(2)**
	(3) Interest credited during the year	**7c(3)**
	(4) Transferred from separate account	**7c(4)**

(5) Other (specify below) **7c(5)**

(6) Total additions **7c(6)**

d Total of balance and additions (add **b** and **c** (6)) **7d**

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)**

(2) Administration charge made by carrier **7e(2)**

(3) Transferred to separate account **7e(3)**

(4) Other (specify below) **7e(4)**

(5) Total deductions **7e(5)**

f Balance at the end of the current year (subtract **e**(5) from **d**) **7f**

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

a ☒ Health (other than dental or vision) **b** ☐ Dental **c** ☐ Vision **d** ☐ Life insurance

e ☐ Temporary disablility (accident and sickness) **f** ☐ Long-term disability **g** ☐ Supplemental unemployment **h** ☐ Prescription drug

i ☐ Stop loss (large deductible) **j** ☐ HMO contract **k** ☐ PPO contract **l** ☐ Indemnity contract

m ☐ Other (specify)

9 Experience related contracts

a Premiums: (1) Amount received **9a(1)**

(2) Increase (decrease) in amount due but unpaid **9a(2)**

(3) Increase (decrease) in unearned premium reserve **9a(3)**

(4) Earned ((1)+(2)-(3)) **9a(4)**

b Benefit charges: (1) Claims paid **9b(1)**

(2) Increase (decrease) in claim reserves **9b(2)**

(3) Incurred claims (add (1) and (2)) **9b(3)**

(4) Claims charged **9b(4)**

c Remainder of premium: (1) Retention charges (on an accrual basis) –

(A) Commissions **9c(1)(A)**

(B) Administrative service or other fees **9c(1)(B)**

(C) Other specific acquisition costs **9c(1)(C)**

(D) Other expenses **9c(1)(D)**

(E) Taxes **9c(1)(E)**

(F) Charges for risks or other contingencies **9c(1)(F)**

(G) Other retention charges **9c(1)(G)**

(H) Total Retention **9c(1)(H)**

(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.) **9c(2)**

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement **9d(1)**

(2) Claim reserves **9d(2)**

(3) Other reserves **9d(3)**

e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) **9e**

10 Nonexperience-rated contracts

a Total premiums or subscription charges paid to carrier **10a** $12,184

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount **10b**

Specify nature of costs below:

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is “Yes,” specify the information not provided.

SCHEDULE A Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210 - 0110

2016

This Form is Open to Public Inspection

For the calendar plan year 2016 or fiscal plan year beginning January 01, 2016, and ending December 31, 2016

A Name of plan

INTERCONTINENTAL AT DORAL MIAMI HEALTH AND WELFARE PLAN

B Three-digit plan number (PN) 501

C Plan sponsor's name as shown on line 2a of Form 5500

INTERCONTINENTAL AT DORAL MIAMI

D Employer Identification Number (EIN) [redacted]2710

Part I · **Information Concerning Insurance Contract Coverage, Fees, and Commissions.** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information

(a) Name of insurance carrier

AMERICAN PUBLIC LIFE INSURANCE COMPANY

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Aproximate number of persons covered at end of policy or contract year	Policy or contract year **(f)** From	**(g)** To
[redacted]9942	60801	APSB22134	49	01/01/2016	12/31/2016

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid: $3,744

(b) Total amount of fees paid:

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

THE SOUTHERN REGION LLC
6151 LAKE OSPREY DR, 3RD FLOOR
SARASOTA FL 34240

(b) Amount of sales and base commissions paid	Fees and other commissions paid **(c)** Amount	**(d)** Purpose	**(e)** Organization code
$2,081			3

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC
4565 PAYSPHERE CIRCLE
CHICAGO IL 60674

(b) Amount of sales and base commissions paid	Fees and other commissions paid **(c)** Amount	**(d)** Purpose	**(e)** Organization code
$1,663			3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. **Schedule A (Form 5500) 2016 v.092308.1**

Part II · **Investment and Annuity Contract Information** Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end **4**

5 Current value of plan's interest under this contract in separate accounts at year end **5**

6 Contracts With Allocated Funds

a State the basis of premium rates

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquision **6d**

or retention of the contract or policy, enter amount
Specify nature of costs

e Type of contract **(1)** ☐ individual policies **(2)** ☐ group deferred annuity **(3)** ☐ other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract **(1)** ☐ deposit administration **(2)** ☐ immediate participation guarantee **(3)** ☐ guaranteed investment **(4)** ☐ other

b Balance at the end of the previous year		**7b**
c Additions: (1) Contributions deposited during the year	**7c(1)**	
(2) Dividends and credits	**7c(2)**	
(3) Interest credited during the year	**7c(3)**	
(4) Transferred from separate account	**7c(4)**	
(5) Other (specify below)	**7c(5)**	
(6) Total additions		**7c(6)**
d Total of balance and additions (add **b** and **c** (6))		**7d**
e Deductions:		
(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**	
(2) Administration charge made by carrier	**7e(2)**	
(3) Transferred to separate account	**7e(3)**	
(4) Other (specify below)	**7e(4)**	
(5) Total deductions		**7e(5)**
f Balance at the end of the current year (subtract **e**(5) from **d**)		**7f**

Part III **Welfare Benefit Contract Information**

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

a ☒ Health (other than dental or vision) **b** ☐ Dental **c** ☐ Vision **d** ☐ Life insurance
e ☐ Temporary disablility (accident and sickness) **f** ☐ Long-term disability **g** ☐ Supplemental unemployment **h** ☐ Prescription drug
i ☐ Stop loss (large deductible) **j** ☐ HMO contract **k** ☐ PPO contract **l** ☒ Indemnity contract
m ☐ Other (specify)

9 Experience related contracts

a Premiums: (1) Amount received	**9a(1)**	
(2) Increase (decrease) in amount due but unpaid	**9a(2)**	
(3) Increase (decrease) in unearned premium reserve	**9a(3)**	
(4) Earned ((1)+(2)-(3))		**9a(4)**
b Benefit charges: (1) Claims paid	**9b(1)**	
(2) Increase (decrease) in claim reserves	**9b(2)**	
(3) Incurred claims (add (1) and (2))		**9b(3)**
(4) Claims charged		**9b(4)**
c Remainder of premium: (1) Retention charges (on an accrual basis) –		
(A) Commissions	**9c(1)(A)**	
(B) Administrative service or other fees	**9c(1)(B)**	
(C) Other specific acquisition costs	**9c(1)(C)**	
(D) Other expenses	**9c(1)(D)**	
(E) Taxes	**9c(1)(E)**	
(F) Charges for risks or other contingencies	**9c(1)(F)**	
(G) Other retention charges	**9c(1)(G)**	
(H) Total Retention		**9c(1)(H)**
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)		**9c(2)**
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		**9d(1)**
(2) Claim reserves		**9d(2)**
(3) Other reserves		**9d(3)**
e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).)		**9e**

10 Nonexperience-rated contracts

a Total premiums or subscription charges paid to carrier	**10a**	$20,822
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount Specify nature of costs below:	**10b**	

Part IV **Provision of Information**

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is "Yes," specify the information not provided.

SCHEDULE A Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210 - 0110

2016

This Form is Open to Public Inspection

For the calendar plan year 2016 or fiscal plan year beginning January 01, 2016, and ending December 31, 2016

A Name of plan

INTERCONTINENTAL AT DORAL MIAMI HEALTH AND WELFARE PLAN

B Three-digit plan number (PN) 501

C Plan sponsor's name as shown on line 2a of Form 5500

INTERCONTINENTAL AT DORAL MIAMI

D Employer Identification Number (EIN) [redacted]2710

Part I · **Information Concerning Insurance Contract Coverage, Fees, and Commissions.** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information

(a) Name of insurance carrier

COVENTRY HEALTH CARE OF FLORIDA, INC.

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Aproximate number of persons covered at end of policy or contract year	Policy or contract year **(f)** From	**(g)** To
[redacted]441	95114	9885280000	165	01/01/2016	12/31/2016

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid: $42,043

(b) Total amount of fees paid:

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC
4565 PAYSPHERE CIRCLE
CHICAGO IL 60674

(b) Amount of sales and base commissions paid	Fees and other commissions paid **(c)** Amount	**(d)** Purpose	**(e)** Organization code
$42,043			3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. **Schedule A (Form 5500) 2016 v.092308.1**

Part II · **Investment and Annuity Contract Information** Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end **4**

5 Current value of plan's interest under this contract in separate accounts at year end **5**

6 Contracts With Allocated Funds

a State the basis of premium rates

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquision or retention of the contract or policy, enter amount **6d**

Specify nature of costs

e Type of contract **(1)** ☐ individual policies **(2)** ☐ group deferred annuity **(3)** ☐ other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract **(1)** ☐ deposit administration **(2)** ☐ immediate participation guarantee **(3)** ☐ guaranteed investment **(4)** ☐ other

b Balance at the end of the previous year **7b**

c Additions: (1) Contributions deposited during the year **7c(1)**

(2) Dividends and credits **7c(2)**

(3) Interest credited during the year **7c(3)**

(4) Transferred from separate account **7c(4)**

(5) Other (specify below) **7c(5)**

(6) Total additions **7c(6)**

d Total of balance and additions (add **b** and **c** (6)) **7d**

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)**

(2) Administration charge made by carrier **7e(2)**

(3) Transferred to separate account **7e(3)**

(4) Other (specify below) **7e(4)**

(5) Total deductions **7e(5)**

f Balance at the end of the current year (subtract **e**(5) from **d**) **7f**

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

a ☒ Health (other than dental or vision) **b** ☐ Dental **c** ☐ Vision **d** ☐ Life insurance

e ☐ Temporary disablility (accident and sickness) **f** ☐ Long-term disability **g** ☐ Supplemental unemployment **h** ☐ Prescription drug

i ☐ Stop loss (large deductible) **j** ☒ HMO contract **k** ☐ PPO contract **l** ☐ Indemnity contract

m ☐ Other (specify)

9 Experience related contracts

a Premiums: (1) Amount received **9a(1)**

(2) Increase (decrease) in amount due but unpaid **9a(2)**

(3) Increase (decrease) in unearned premium reserve **9a(3)**

(4) Earned ((1)+(2)-(3)) **9a(4)**

b Benefit charges: (1) Claims paid **9b(1)**

(2) Increase (decrease) in claim reserves **9b(2)**

(3) Incurred claims (add (1) and (2)) **9b(3)**

(4) Claims charged **9b(4)**

c Remainder of premium: (1) Retention charges (on an accrual basis) –

(A) Commissions **9c(1)(A)**

(B) Administrative service or other fees **9c(1)(B)**

(C) Other specific acquisition costs **9c(1)(C)**

(D) Other expenses **9c(1)(D)**

(E) Taxes **9c(1)(E)**

(F) Charges for risks or other contingencies **9c(1)(F)**

(G) Other retention charges **9c(1)(G)**

(H) Total Retention **9c(1)(H)**

(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.) **9c(2)**

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement **9d(1)**

(2) Claim reserves **9d(2)**

(3) Other reserves **9d(3)**

e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) **9e**

10 Nonexperience-rated contracts

a Total premiums or subscription charges paid to carrier **10a** $700,381

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount **10b**

Specify nature of costs below:

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is “Yes,” specify the information not provided.

SCHEDULE A Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210 - 0110

2016

This Form is Open to Public Inspection

For the calendar plan year 2016 or fiscal plan year beginning January 01, 2016, and ending December 31, 2016

A Name of plan

INTERCONTINENTAL AT DORAL MIAMI HEALTH AND WELFARE PLAN

B Three-digit plan number (PN) 501

C Plan sponsor's name as shown on line 2a of Form 5500

INTERCONTINENTAL AT DORAL MIAMI

D Employer Identification Number (EIN) [redacted]2710

Part I · **Information Concerning Insurance Contract Coverage, Fees, and Commissions.** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information

(a) Name of insurance carrier

FIDELITY SECURITY LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Aproximate number of persons covered at end of policy or contract year	Policy or contract year (f) From	(g) To
[redacted]9844	71870	9811431	89	01/01/2016	12/31/2016

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid: $556

(b) Total amount of fees paid:

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC
4565 PAYSPHERE CIRCLE
CHICAGO IL 60674

(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount	(d) Purpose	(e) Organization code
$556			3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. **Schedule A (Form 5500) 2016 v.092308.1**

Part II · **Investment and Annuity Contract Information** Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	**4**
5	Current value of plan's interest under this contract in separate accounts at year end	**5**
6	Contracts With Allocated Funds	
a	State the basis of premium rates	
b	Premiums paid to carrier	**6b**
c	Premiums due but unpaid at the end of the year	**6c**
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquision or retention of the contract or policy, enter amount Specify nature of costs	**6d**
e	Type of contract **(1)** ☐ individual policies **(2)** ☐ group deferred annuity **(3)** ☐ other (specify)	
f	If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ☐	
7	Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)	
a	Type of contract **(1)** ☐ deposit administration **(2)** ☐ immediate participation guarantee **(3)** ☐ guaranteed investment **(4)** ☐ other	
b	Balance at the end of the previous year	**7b**
c	Additions: (1) Contributions deposited during the year	**7c(1)**
	(2) Dividends and credits	**7c(2)**
	(3) Interest credited during the year	**7c(3)**
	(4) Transferred from separate account	**7c(4)**

(5) Other (specify below) **7c(5)**

(6) Total additions **7c(6)**

d Total of balance and additions (add **b** and **c** (6)) **7d**

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)**

(2) Administration charge made by carrier **7e(2)**

(3) Transferred to separate account **7e(3)**

(4) Other (specify below) **7e(4)**

(5) Total deductions **7e(5)**

f Balance at the end of the current year (subtract **e**(5) from **d**) **7f**

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

a ☐ Health (other than dental or vision) **b** ☐ Dental **c** ☒ Vision **d** ☐ Life insurance

e ☐ Temporary disablility (accident and sickness) **f** ☐ Long-term disability **g** ☐ Supplemental unemployment **h** ☐ Prescription drug

i ☐ Stop loss (large deductible) **j** ☐ HMO contract **k** ☐ PPO contract **l** ☐ Indemnity contract

m ☐ Other (specify)

9 Experience related contracts

a Premiums: (1) Amount received **9a(1)**

(2) Increase (decrease) in amount due but unpaid **9a(2)**

(3) Increase (decrease) in unearned premium reserve **9a(3)**

(4) Earned ((1)+(2)-(3)) **9a(4)**

b Benefit charges: (1) Claims paid **9b(1)**

(2) Increase (decrease) in claim reserves **9b(2)**

(3) Incurred claims (add (1) and (2)) **9b(3)**

(4) Claims charged **9b(4)**

c Remainder of premium: (1) Retention charges (on an accrual basis) –

(A) Commissions **9c(1)(A)**

(B) Administrative service or other fees **9c(1)(B)**

(C) Other specific acquisition costs **9c(1)(C)**

(D) Other expenses **9c(1)(D)**

(E) Taxes **9c(1)(E)**

(F) Charges for risks or other contingencies **9c(1)(F)**

(G) Other retention charges **9c(1)(G)**

(H) Total Retention **9c(1)(H)**

(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.) **9c(2)**

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement **9d(1)**

(2) Claim reserves **9d(2)**

(3) Other reserves **9d(3)**

e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) **9e**

10 Nonexperience-rated contracts

a Total premiums or subscription charges paid to carrier **10a** $5,262

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount **10b**

Specify nature of costs below:

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is “Yes,” specify the information not provided.

SCHEDULE A Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210 - 0110

2016

This Form is Open to Public Inspection

For the calendar plan year 2016 or fiscal plan year beginning January 01, 2016, and ending December 31, 2016

A Name of plan

INTERCONTINENTAL AT DORAL MIAMI HEALTH AND WELFARE PLAN

B Three-digit plan number (PN) 501

C Plan sponsor's name as shown on line 2a of Form 5500

INTERCONTINENTAL AT DORAL MIAMI

D Employer Identification Number (EIN) [redacted]2710

Part I · **Information Concerning Insurance Contract Coverage, Fees, and Commissions.** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information

(a) Name of insurance carrier

PRE-PAID LEGAL SERVICES, INC. DBA LEGALSHIELD

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Aproximate number of persons covered at end of policy or contract year	Policy or contract year (f) From	(g) To
[redacted]6728	00000	44350	1	01/01/2016	12/31/2016

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid: $32

(b) Total amount of fees paid

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

OTTO CAMEJO
751 WREN AVE
MIAMI SPRINGS FL 33166

(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount	(d) Purpose	(e) Organization code
$32			4

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. **Schedule A (Form 5500) 2016 v.092308.1**

Part II · **Investment and Annuity Contract Information** Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	**4**
5	Current value of plan's interest under this contract in separate accounts at year end	**5**
6	Contracts With Allocated Funds	
a	State the basis of premium rates	
b	Premiums paid to carrier	**6b**
c	Premiums due but unpaid at the end of the year	**6c**
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquision or retention of the contract or policy, enter amount Specify nature of costs	**6d**
e	Type of contract **(1)** ☐ individual policies **(2)** ☐ group deferred annuity **(3)** ☐ other (specify)	
f	If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ☐	
7	Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)	
a	Type of contract **(1)** ☐ deposit administration **(2)** ☐ immediate participation guarantee **(3)** ☐ guaranteed investment **(4)** ☐ other	
b	Balance at the end of the previous year	**7b**
c	Additions: (1) Contributions deposited during the year	**7c(1)**
	(2) Dividends and credits	**7c(2)**
	(3) Interest credited during the year	**7c(3)**
	(4) Transferred from separate account	**7c(4)**

(5) Other (specify below) **7c(5)**

(6) Total additions **7c(6)**

d Total of balance and additions (add **b** and **c** (6)) **7d**

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)**

(2) Administration charge made by carrier **7e(2)**

(3) Transferred to separate account **7e(3)**

(4) Other (specify below) **7e(4)**

(5) Total deductions **7e(5)**

f Balance at the end of the current year (subtract **e**(5) from **d**) **7f**

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

a ☐ Health (other than dental or vision) **b** ☐ Dental **c** ☐ Vision **d** ☐ Life insurance

e ☐ Temporary disablility (accident and sickness) **f** ☐ Long-term disability **g** ☐ Supplemental unemployment **h** ☐ Prescription drug

i ☐ Stop loss (large deductible) **j** ☐ HMO contract **k** ☐ PPO contract **l** ☐ Indemnity contract

m ☒ Other (specify) LEGAL SERVICES PLAN MEMBERSHIPS

9 Experience related contracts

a Premiums: (1) Amount received **9a(1)**

(2) Increase (decrease) in amount due but unpaid **9a(2)**

(3) Increase (decrease) in unearned premium reserve **9a(3)**

(4) Earned ((1)+(2)-(3)) **9a(4)**

b Benefit charges: (1) Claims paid **9b(1)**

(2) Increase (decrease) in claim reserves **9b(2)**

(3) Incurred claims (add (1) and (2)) **9b(3)**

(4) Claims charged **9b(4)**

c Remainder of premium: (1) Retention charges (on an accrual basis) –

(A) Commissions **9c(1)(A)**

(B) Administrative service or other fees **9c(1)(B)**

(C) Other specific acquisition costs **9c(1)(C)**

(D) Other expenses **9c(1)(D)**

(E) Taxes **9c(1)(E)**

(F) Charges for risks or other contingencies **9c(1)(F)**

(G) Other retention charges **9c(1)(G)**

(H) Total Retention **9c(1)(H)**

(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.) **9c(2)**

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement **9d(1)**

(2) Claim reserves **9d(2)**

(3) Other reserves **9d(3)**

e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) **9e**

10 Nonexperience-rated contracts

a Total premiums or subscription charges paid to carrier **10a** $207

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount **10b**

Specify nature of costs below:

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is “Yes,” specify the information not provided.

SCHEDULE A Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210 - 0110

2016

This Form is Open to Public Inspection

For the calendar plan year 2016 or fiscal plan year beginning January 01, 2016, and ending December 31, 2016

A Name of plan

INTERCONTINENTAL AT DORAL MIAMI HEALTH AND WELFARE PLAN

B Three-digit plan number (PN) 501

C Plan sponsor's name as shown on line 2a of Form 5500

INTERCONTINENTAL AT DORAL MIAMI

D Employer Identification Number (EIN) [redacted]2710

Part I · **Information Concerning Insurance Contract Coverage, Fees, and Commissions.** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information

(a) Name of insurance carrier

SOLSTICE BENEFITS, INC

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Aproximate number of persons covered at end of policy or contract year	Policy or contract year (f) From	(g) To
[redacted]7982	12341	98	130	01/01/2016	12/31/2016

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid: $2,662

(b) Total amount of fees paid:

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC
4565 PAYSPHERE CIRCLE
CHICAGO IL 60674

(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount	(d) Purpose	(e) Organization code
$2,662			3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. **Schedule A (Form 5500) 2016 v.092308.1**

Part II · **Investment and Annuity Contract Information** Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end **4**

5 Current value of plan's interest under this contract in separate accounts at year end **5**

6 Contracts With Allocated Funds

a State the basis of premium rates

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquision or retention of the contract or policy, enter amount **6d**

Specify nature of costs

e Type of contract **(1)** ☐ individual policies **(2)** ☐ group deferred annuity **(3)** ☐ other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract **(1)** ☐ deposit administration **(2)** ☐ immediate participation guarantee **(3)** ☐ guaranteed investment **(4)** ☐ other

b Balance at the end of the previous year **7b**

c Additions: (1) Contributions deposited during the year **7c(1)**

(2) Dividends and credits **7c(2)**

(3) Interest credited during the year **7c(3)**

(4) Transferred from separate account **7c(4)**

(5) Other (specify below) **7c(5)**

(6) Total additions **7c(6)**

d Total of balance and additions (add **b** and **c** (6)) **7d**

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)**

(2) Administration charge made by carrier **7e(2)**

(3) Transferred to separate account **7e(3)**

(4) Other (specify below) **7e(4)**

(5) Total deductions **7e(5)**

f Balance at the end of the current year (subtract **e**(5) from **d**) **7f**

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

a ☐ Health (other than dental or vision) **b** ☒ Dental **c** ☐ Vision **d** ☐ Life insurance

e ☐ Temporary disablility (accident and sickness) **f** ☐ Long-term disability **g** ☐ Supplemental unemployment **h** ☐ Prescription drug

i ☐ Stop loss (large deductible) **j** ☐ HMO contract **k** ☐ PPO contract **l** ☐ Indemnity contract

m ☐ Other (specify)

9 Experience related contracts

a Premiums: (1) Amount received **9a(1)**

(2) Increase (decrease) in amount due but unpaid **9a(2)**

(3) Increase (decrease) in unearned premium reserve **9a(3)**

(4) Earned ((1)+(2)-(3)) **9a(4)**

b Benefit charges: (1) Claims paid **9b(1)**

(2) Increase (decrease) in claim reserves **9b(2)**

(3) Incurred claims (add (1) and (2)) **9b(3)**

(4) Claims charged **9b(4)**

c Remainder of premium: (1) Retention charges (on an accrual basis) –

(A) Commissions **9c(1)(A)**

(B) Administrative service or other fees **9c(1)(B)**

(C) Other specific acquisition costs **9c(1)(C)**

(D) Other expenses **9c(1)(D)**

(E) Taxes **9c(1)(E)**

(F) Charges for risks or other contingencies **9c(1)(F)**

(G) Other retention charges **9c(1)(G)**

(H) Total Retention **9c(1)(H)**

(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.) **9c(2)**

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement **9d(1)**

(2) Claim reserves **9d(2)**

(3) Other reserves **9d(3)**

e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) **9e**

10 Nonexperience-rated contracts

a Total premiums or subscription charges paid to carrier **10a** $20,989

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount **10b**

Specify nature of costs below:

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is “Yes,” specify the information not provided.

SCHEDULE A Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210 - 0110

2016

This Form is Open to Public Inspection

For the calendar plan year 2016 or fiscal plan year beginning January 01, 2016, and ending December 31, 2016

A Name of plan

INTERCONTINENTAL AT DORAL MIAMI HEALTH AND WELFARE PLAN

B Three-digit plan number (PN) 501

C Plan sponsor's name as shown on line 2a of Form 5500

INTERCONTINENTAL AT DORAL MIAMI

D Employer Identification Number (EIN) [redacted]2710

Part I · **Information Concerning Insurance Contract Coverage, Fees, and Commissions.** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information

(a) Name of insurance carrier

UNUM LIFE INSURANCE COMPANY OF AMERICA

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Aproximate number of persons covered at end of policy or contract year	Policy or contract year (f) From	(g) To
[redacted]8678	62235	632039	148	01/01/2016	12/31/2016

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
$597	$75

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC
4565 PAYSPHERE CIRCLE
CHICAGO IL 60674

(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount	(d) Purpose	(e) Organization code
$597	$75	ADDITIONAL COMPENSATION	3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. **Schedule A (Form 5500) 2016 v.092308.1**

Part II · **Investment and Annuity Contract Information** Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	**4**
5	Current value of plan's interest under this contract in separate accounts at year end	**5**
6	Contracts With Allocated Funds	
a	State the basis of premium rates	
b	Premiums paid to carrier	**6b**
c	Premiums due but unpaid at the end of the year	**6c**
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquision or retention of the contract or policy, enter amount	**6d**
	Specify nature of costs	
e	Type of contract **(1)** ☐ individual policies **(2)** ☐ group deferred annuity **(3)** ☐ other (specify)	
f	If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ☐	
7	Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)	
a	Type of contract **(1)** ☐ deposit administration **(2)** ☐ immediate participation guarantee **(3)** ☐ guaranteed investment **(4)** ☐ other	
b	Balance at the end of the previous year	**7b**
c	Additions: (1) Contributions deposited during the year	**7c(1)**
	(2) Dividends and credits	**7c(2)**
	(3) Interest credited during the year	**7c(3)**
	(4) Transferred from separate account	**7c(4)**

(5) Other (specify below) **7c(5)**

(6) Total additions **7c(6)**

d Total of balance and additions (add **b** and **c** (6)) **7d**

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)**

(2) Administration charge made by carrier **7e(2)**

(3) Transferred to separate account **7e(3)**

(4) Other (specify below) **7e(4)**

(5) Total deductions **7e(5)**

f Balance at the end of the current year (subtract **e**(5) from **d**) **7f**

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

a ☐ Health (other than dental or vision) **b** ☐ Dental **c** ☐ Vision **d** ☒ Life insurance

e ☒ Temporary disablility (accident and sickness) **f** ☐ Long-term disability **g** ☐ Supplemental unemployment **h** ☐ Prescription drug

i ☐ Stop loss (large deductible) **j** ☐ HMO contract **k** ☐ PPO contract **l** ☐ Indemnity contract

m ☒ Other (specify) ACCIDENTAL DEATH AND DISMEMBERMENT

9 Experience related contracts

a Premiums: (1) Amount received **9a(1)**

(2) Increase (decrease) in amount due but unpaid **9a(2)**

(3) Increase (decrease) in unearned premium reserve **9a(3)**

(4) Earned ((1)+(2)-(3)) **9a(4)**

b Benefit charges: (1) Claims paid **9b(1)**

(2) Increase (decrease) in claim reserves **9b(2)**

(3) Incurred claims (add (1) and (2)) **9b(3)**

(4) Claims charged **9b(4)**

c Remainder of premium: (1) Retention charges (on an accrual basis) –

(A) Commissions **9c(1)(A)**

(B) Administrative service or other fees **9c(1)(B)**

(C) Other specific acquisition costs **9c(1)(C)**

(D) Other expenses **9c(1)(D)**

(E) Taxes **9c(1)(E)**

(F) Charges for risks or other contingencies **9c(1)(F)**

(G) Other retention charges **9c(1)(G)**

(H) Total Retention **9c(1)(H)**

(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.) **9c(2)**

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement **9d(1)**

(2) Claim reserves **9d(2)**

(3) Other reserves **9d(3)**

e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) **9e**

10 Nonexperience-rated contracts

a Total premiums or subscription charges paid to carrier **10a** $6,462

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount **10b**

Specify nature of costs below:

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is “Yes,” specify the information not provided.

SCHEDULE A Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210 - 0110

2016

This Form is Open to Public Inspection

For the calendar plan year 2016 or fiscal plan year beginning January 01, 2016, and ending December 31, 2016

A Name of plan

INTERCONTINENTAL AT DORAL MIAMI HEALTH AND WELFARE PLAN

B Three-digit plan number (PN) 501

C Plan sponsor's name as shown on line 2a of Form 5500

INTERCONTINENTAL AT DORAL MIAMI

D Employer Identification Number (EIN) [redacted]2710

Part I · **Information Concerning Insurance Contract Coverage, Fees, and Commissions.** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information

(a) Name of insurance carrier

UNUM LIFE INSURANCE COMPANY OF AMERICA

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Aproximate number of persons covered at end of policy or contract year	Policy or contract year (f) From	(g) To
[redacted]8678	62235	632040	31	01/01/2016	12/31/2016

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
$648	$81

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFTIS, LLC
4565 PAYSPHERE CIRCLE
CHICAGO IL 60674

(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount	(d) Purpose	(e) Organization code
$648	$81	ADDITIONAL COMPENSATION	3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. **Schedule A (Form 5500) 2016 v.092308.1**

Part II · **Investment and Annuity Contract Information** Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	**4**
5	Current value of plan's interest under this contract in separate accounts at year end	**5**
6	Contracts With Allocated Funds	
a	State the basis of premium rates	
b	Premiums paid to carrier	**6b**
c	Premiums due but unpaid at the end of the year	**6c**
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquision or retention of the contract or policy, enter amount Specify nature of costs	**6d**
e	Type of contract **(1)** ☐ individual policies **(2)** ☐ group deferred annuity **(3)** ☐ other (specify)	
f	If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ☐	
7	Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)	
a	Type of contract **(1)** ☐ deposit administration **(2)** ☐ immediate participation guarantee **(3)** ☐ guaranteed investment **(4)** ☐ other	
b	Balance at the end of the previous year	**7b**
c	Additions: (1) Contributions deposited during the year	**7c(1)**
	(2) Dividends and credits	**7c(2)**
	(3) Interest credited during the year	**7c(3)**
	(4) Transferred from separate account	**7c(4)**

(5) Other (specify below) **7c(5)**

(6) Total additions **7c(6)**

d Total of balance and additions (add **b** and **c** (6)) **7d**

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)**

(2) Administration charge made by carrier **7e(2)**

(3) Transferred to separate account **7e(3)**

(4) Other (specify below) **7e(4)**

(5) Total deductions **7e(5)**

f Balance at the end of the current year (subtract **e**(5) from **d**) **7f**

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

a ☐ Health (other than dental or vision) **b** ☐ Dental **c** ☐ Vision **d** ☐ Life insurance

e ☒ Temporary disablility (accident and sickness) **f** ☐ Long-term disability **g** ☐ Supplemental unemployment **h** ☐ Prescription drug

i ☐ Stop loss (large deductible) **j** ☐ HMO contract **k** ☐ PPO contract **l** ☐ Indemnity contract

m ☐ Other (specify)

9 Experience related contracts

a Premiums: (1) Amount received **9a(1)**

(2) Increase (decrease) in amount due but unpaid **9a(2)**

(3) Increase (decrease) in unearned premium reserve **9a(3)**

(4) Earned ((1)+(2)-(3)) **9a(4)**

b Benefit charges: (1) Claims paid **9b(1)**

(2) Increase (decrease) in claim reserves **9b(2)**

(3) Incurred claims (add (1) and (2)) **9b(3)**

(4) Claims charged **9b(4)**

c Remainder of premium: (1) Retention charges (on an accrual basis) –

(A) Commissions **9c(1)(A)**

(B) Administrative service or other fees **9c(1)(B)**

(C) Other specific acquisition costs **9c(1)(C)**

(D) Other expenses **9c(1)(D)**

(E) Taxes **9c(1)(E)**

(F) Charges for risks or other contingencies **9c(1)(F)**

(G) Other retention charges **9c(1)(G)**

(H) Total Retention **9c(1)(H)**

(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.) **9c(2)**

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement **9d(1)**

(2) Claim reserves **9d(2)**

(3) Other reserves **9d(3)**

e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) **9e**

10 Nonexperience-rated contracts

a Total premiums or subscription charges paid to carrier **10a** $7,018

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount **10b**

Specify nature of costs below:

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is “Yes,” specify the information not provided.

SCHEDULE A Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210 - 0110

2016

This Form is Open to Public Inspection

For the calendar plan year 2016 or fiscal plan year beginning January 01, 2016, and ending December 31, 2016

A Name of plan

INTERCONTINENTAL AT DORAL MIAMI HEALTH AND WELFARE PLAN

B Three-digit plan number (PN) 501

C Plan sponsor's name as shown on line 2a of Form 5500

INTERCONTINENTAL AT DORAL MIAMI

D Employer Identification Number (EIN) [redacted]2710

Part I · **Information Concerning Insurance Contract Coverage, Fees, and Commissions.** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information

(a) Name of insurance carrier

UNUM LIFE INSURANCE COMPANY OF AMERICA

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Aproximate number of persons covered at end of policy or contract year	Policy or contract year (f) From	(g) To
[redacted]8678	62235	632041	21	01/01/2016	12/31/2016

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
$1,224	$102

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC
4565 PAYSPHERE CIRCLE
CHICAGO IL 60674

(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount	(d) Purpose	(e) Organization code
$1,224	$102	ADDITIONAL COMPENSATION	3

Part II · **Investment and Annuity Contract Information**

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end **4**

5 Current value of plan's interest under this contract in separate accounts at year end **5**

6 Contracts With Allocated Funds

a State the basis of premium rates

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquision or retention of the contract or policy, enter amount **6d**

Specify nature of costs

e Type of contract **(1)** ☐ individual policies **(2)** ☐ group deferred annuity **(3)** ☐ other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract **(1)** ☐ deposit administration **(2)** ☐ immediate participation guarantee **(3)** ☐ guaranteed investment **(4)** ☐ other

b Balance at the end of the previous year **7b**

c Additions: (1) Contributions deposited during the year **7c(1)**

(2) Dividends and credits **7c(2)**

(3) Interest credited during the year **7c(3)**

(4) Transferred from separate account **7c(4)**

(5) Other (specify below) **7c(5)**

(6) Total additions **7c(6)**

d Total of balance and additions (add **b** and **c** (6)) **7d**

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)**

(2) Administration charge made by carrier **7e(2)**

(3) Transferred to separate account **7e(3)**

(4) Other (specify below) **7e(4)**

(5) Total deductions **7e(5)**

f Balance at the end of the current year (subtract **e**(5) from **d**) **7f**

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

a ☐ Health (other than dental or vision) **b** ☐ Dental **c** ☐ Vision **d** ☒ Life insurance

e ☐ Temporary disablility (accident and sickness) **f** ☐ Long-term disability **g** ☐ Supplemental unemployment **h** ☐ Prescription drug

i ☐ Stop loss (large deductible) **j** ☐ HMO contract **k** ☐ PPO contract **l** ☐ Indemnity contract

m ☒ Other (specify) ACCIDENTAL DEATH AND DISMEMBERMENT

9 Experience related contracts

a Premiums: (1) Amount received **9a(1)**

(2) Increase (decrease) in amount due but unpaid **9a(2)**

(3) Increase (decrease) in unearned premium reserve **9a(3)**

(4) Earned ((1)+(2)-(3)) **9a(4)**

b Benefit charges: (1) Claims paid **9b(1)**

(2) Increase (decrease) in claim reserves **9b(2)**

(3) Incurred claims (add (1) and (2)) **9b(3)**

(4) Claims charged **9b(4)**

c Remainder of premium: (1) Retention charges (on an accrual basis) –

(A) Commissions **9c(1)(A)**

(B) Administrative service or other fees **9c(1)(B)**

(C) Other specific acquisition costs **9c(1)(C)**

(D) Other expenses **9c(1)(D)**

(E) Taxes **9c(1)(E)**

(F) Charges for risks or other contingencies **9c(1)(F)**

(G) Other retention charges **9c(1)(G)**

(H) Total Retention **9c(1)(H)**

(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.) **9c(2)**

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement **9d(1)**

(2) Claim reserves **9d(2)**

(3) Other reserves **9d(3)**

e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) **9e**

10 Nonexperience-rated contracts

a Total premiums or subscription charges paid to carrier **10a** $8,904

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount **10b**

Specify nature of costs below:

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is “Yes,” specify the information not provided.

SCHEDULE A Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210 - 0110

2016

This Form is Open to Public Inspection

For the calendar plan year 2016 or fiscal plan year beginning January 01, 2016, and ending December 31, 2016

A Name of plan

INTERCONTINENTAL AT DORAL MIAMI HEALTH AND WELFARE PLAN

B Three-digit plan number (PN) 501

C Plan sponsor's name as shown on line 2a of Form 5500

INTERCONTINENTAL AT DORAL MIAMI

D Employer Identification Number (EIN) [redacted]2710

Part I · **Information Concerning Insurance Contract Coverage, Fees, and Commissions.** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information

(a) Name of insurance carrier

UNUM LIFE INSURANCE COMPANY OF AMERICA

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Aproximate number of persons covered at end of policy or contract year	Policy or contract year (f) From	(g) To
[redacted]8678	62235	632141	4	01/01/2016	12/31/2016

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
$235	$20

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC
4565 PAYSPHERE CIRCLE
CHICAGO IL 60674

(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount	(d) Purpose	(e) Organization code
$235	$20	ADDITIONAL COMPENSATION	3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. **Schedule A (Form 5500) 2016 v.092308.1**

Part II · **Investment and Annuity Contract Information** Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	**4**
5	Current value of plan's interest under this contract in separate accounts at year end	**5**
6	Contracts With Allocated Funds	
a	State the basis of premium rates	
b	Premiums paid to carrier	**6b**
c	Premiums due but unpaid at the end of the year	**6c**
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquision or retention of the contract or policy, enter amount	**6d**
	Specify nature of costs	
e	Type of contract **(1)** ☐ individual policies **(2)** ☐ group deferred annuity **(3)** ☐ other (specify)	
f	If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ☐	
7	Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)	
a	Type of contract **(1)** ☐ deposit administration **(2)** ☐ immediate participation guarantee **(3)** ☐ guaranteed investment **(4)** ☐ other	
b	Balance at the end of the previous year	**7b**
c	Additions: (1) Contributions deposited during the year	**7c(1)**
	(2) Dividends and credits	**7c(2)**
	(3) Interest credited during the year	**7c(3)**
	(4) Transferred from separate account	**7c(4)**

(5) Other (specify below) **7c(5)**

(6) Total additions **7c(6)**

d Total of balance and additions (add **b** and **c** (6)) **7d**

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)**

(2) Administration charge made by carrier **7e(2)**

(3) Transferred to separate account **7e(3)**

(4) Other (specify below) **7e(4)**

(5) Total deductions **7e(5)**

f Balance at the end of the current year (subtract **e**(5) from **d**) **7f**

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

a ☐ Health (other than dental or vision) **b** ☐ Dental **c** ☐ Vision **d** ☐ Life insurance

e ☐ Temporary disablility (accident and sickness) **f** ☒ Long-term disability **g** ☐ Supplemental unemployment **h** ☐ Prescription drug

i ☐ Stop loss (large deductible) **j** ☐ HMO contract **k** ☐ PPO contract **l** ☐ Indemnity contract

m ☒ Other (specify) EMPLOYEE ASSISTANCE PROGRAM

9 Experience related contracts

a Premiums: (1) Amount received **9a(1)**

(2) Increase (decrease) in amount due but unpaid **9a(2)**

(3) Increase (decrease) in unearned premium reserve **9a(3)**

(4) Earned ((1)+(2)-(3)) **9a(4)**

b Benefit charges: (1) Claims paid **9b(1)**

(2) Increase (decrease) in claim reserves **9b(2)**

(3) Incurred claims (add (1) and (2)) **9b(3)**

(4) Claims charged **9b(4)**

c Remainder of premium: (1) Retention charges (on an accrual basis) –

(A) Commissions **9c(1)(A)**

(B) Administrative service or other fees **9c(1)(B)**

(C) Other specific acquisition costs **9c(1)(C)**

(D) Other expenses **9c(1)(D)**

(E) Taxes **9c(1)(E)**

(F) Charges for risks or other contingencies **9c(1)(F)**

(G) Other retention charges **9c(1)(G)**

(H) Total Retention **9c(1)(H)**

(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.) **9c(2)**

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement **9d(1)**

(2) Claim reserves **9d(2)**

(3) Other reserves **9d(3)**

e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) **9e**

10 Nonexperience-rated contracts

a Total premiums or subscription charges paid to carrier **10a** $1,728

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount **10b**

Specify nature of costs below:

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is “Yes,” specify the information not provided.

Form 5500

Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

OMB Nos. 1210 - 0110
1210 - 0089

2016

This Form is Open to Public Inspection

Complete all entries in accordance with the instructions to the Form 5500.

Part I · Annual Report Identification Information

For calendar plan year 2016 or fiscal plan year beginning January 01, 2016 , and ending December 31, 2016

A a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions)for ☐ a multiemployer plan; ☐ a multiple-employer plan; ☐ a DFE (specify) ☒ a single-employer plan;

B This return/report is: ☐ the first return/report; ☐ the final return/report; ☐ an amended return/report; ☐ a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here ☐

D Check box if filling under: ☐ Form 5558; ☐ automatic extension; ☐ the DFVC program; ☐ special extension (enter description)

Part II · Basic Plan Information – enter all requested information.

1a Name of plan

AKUMIN HEALTH PLAN

1b Three-digit plan number (PN) 501

1c Effective date of plan January 01, 2015

2a Plan sponsor's name and address, including room or suite number (Employer, if for a single-employer plan)

AKUMIN
1460 S. VANTAGE WAY SUITE 100
JACKSONVILLE FL 32218

2b Employer Identification Number (EIN) [redacted]3204

2c Sponsor's telephone number 416-917-4184

2d Business code (see instructions) 621498

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.
Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

Signature of plan administrator	Date 07/03/2017	Enter name of individual signing as plan administrator ROHIT NAVANI
Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
Signature of DFE	Date	Enter name of individual signing as DFE

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. **Form 5500 (2016) v.092308.1**

3a Plan administrator's name and address (if same as plan sponsor, enter"Same")

3b Administrator's EIN

3c Administrator's telephone number

4	If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below: **a** Sponsor's name		**4b** EIN **4c** PN
5	Total number of participants at the beginning of the plan year	**5**	201
6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans only complete lines **6a(1), 6a(2), 6b, 6c,** and **6d**)		
a(1)	Total active number of participants at the beginning of the plan year	**6a(1)**	200
a(2)	Total active number of participants at the end of the plan year	**6a(2)**	
b	Retired or separated participants receiving benefits	**6b**	2
c	Other retired or separated participants entitled to future benefits	**6c**	
d	Subtotal. Add lines **6a(2), 6b,** and **6c**	**6d**	289
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**6e**	
f	Total. Add lines **6d** and **6e**	**6f**	
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	0

8a If the plan provides **pension benefits**, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:

b If the plan provides **welfare benefits**, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:

4A 4B 4D 4E 4F 4H 4L

9a Plan funding arrangement (check all that apply)
- **(1)** [X] Insurance
- **(2)** [ ] Section 412(e)(3) insurance contracts
- **(3)** [ ] Trust
- **(4)** [X] General assets of the sponsor

9b Plan benefit arrangement (check all that apply)
- **(1)** [X] Insurance
- **(2)** [ ] Section 412(e)(3) insurance contracts
- **(3)** [ ] Trust
- **(4)** [X] General assets of the sponsor

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached,and, where indicated, enter the number attached (See instructions)

a Pension Schedules
- **(1)** [ ] **R** (Retirement Plan Information)
- **(2)** [ ] **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information)- signed by the plan actuary
- **(3)** [ ] **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

b General Schedules
- **(1)** [ ] **H** (Financial Information)
- **(2)** [ ] **I** (Financial Information – Small Plan)
- **(3)** [X] 6 **A** (Insurance Information)
- **(4)** [ ] **C** (Service Provider Information)
- **(5)** [ ] **D** (DFE/Participating Plan Information)
- **(6)** [ ] **G** (Financial Transaction Schedules)

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

11a If the plan provides welfare benefits, was the plan subject to Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2)..... [ ] Yes [X] No
If "Yes" is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with M-1 filing requirements? (See instructions and 29 CFR 2520.101-2)..... [ ] Yes [ ] No

11c Enter the Receipt Confirmation Code for the 2016 Form M-1 annual report. If the plan was not required to file the 2016 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.) Receipt Confirmation Code

SCHEDULE A Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210 - 0110

2016

This Form is Open to Public Inspection

For the calendar plan year 2016 or fiscal plan year beginning January 01, 2016, and ending December 31, 2016

A Name of plan

AKUMIN HEALTH PLAN

B Three-digit plan number (PN)

501

C Plan sponsor's name as shown on line 2a of Form 5500

AKUMIN

D Employer Identification Number (EIN)

[redacted]3204

Part I · **Information Concerning Insurance Contract Coverage, Fees, and Commissions.** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information

(a) Name of insurance carrier

BLUE CROSS BLUE SHIELD OF FLORIDA

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Aproximate number of persons covered at end of policy or contract year	Policy or contract year (f) From	(g) To
[redacted]5694	98167	B7825	107	01/01/2016	12/31/2016

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid: $17,609

(b) Total amount of fees paid:

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC
1560 SAWGRASS CORPORATE PKWY #300
SUNRISE FL 33323

(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount	(d) Purpose	(e) Organization code
$17,609			3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. **Schedule A (Form 5500) 2016 v.092308.1**

Part II · **Investment and Annuity Contract Information** Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end — **4**

5 Current value of plan's interest under this contract in separate accounts at year end — **5**

6 Contracts With Allocated Funds

a State the basis of premium rates

b Premiums paid to carrier — **6b**

c Premiums due but unpaid at the end of the year — **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquision or retention of the contract or policy, enter amount — **6d**

Specify nature of costs

e Type of contract **(1)** ☐ individual policies **(2)** ☐ group deferred annuity **(3)** ☐ other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract **(1)** ☐ deposit administration **(2)** ☐ immediate participation guarantee **(3)** ☐ guaranteed investment **(4)** ☐ other

b Balance at the end of the previous year — **7b**

c Additions: (1) Contributions deposited during the year — **7c(1)**

(2) Dividends and credits — **7c(2)**

(3) Interest credited during the year — **7c(3)**

(4) Transferred from separate account — **7c(4)**

(5) Other (specify below)	7c(5)		
(6) Total additions		7c(6)	
d Total of balance and additions (add **b** and **c** (6))		7d	
e Deductions:			
(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
(2) Administration charge made by carrier	7e(2)		
(3) Transferred to separate account	7e(3)		
(4) Other (specify below)	7e(4)		
(5) Total deductions		7e(5)	
f Balance at the end of the current year (subtract **e**(5) from **d**)		7f	

Part III **Welfare Benefit Contract Information**

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

a ☒ Health (other than dental or vision)	**b** ☐ Dental	**c** ☐ Vision	**d** ☐ Life insurance
e ☐ Temporary disablility (accident and sickness)	**f** ☐ Long-term disability	**g** ☐ Supplemental unemployment	**h** ☒ Prescription drug
i ☐ Stop loss (large deductible)	**j** ☐ HMO contract	**k** ☒ PPO contract	**l** ☐ Indemnity contract
m ☐ Other (specify)			

9 Experience related contracts

a Premiums: (1) Amount received	9a(1)	$440,228		
(2) Increase (decrease) in amount due but unpaid	9a(2)			
(3) Increase (decrease) in unearned premium reserve	9a(3)			
(4) Earned ((1)+(2)-(3))			9a(4)	$440,228
b Benefit charges: (1) Claims paid	9b(1)	$339,856		
(2) Increase (decrease) in claim reserves	9b(2)			
(3) Incurred claims (add (1) and (2))			9b(3)	$339,856
(4) Claims charged			9b(4)	$339,856
c Remainder of premium: (1) Retention charges (on an accrual basis) –				
(A) Commissions	9c(1)(A)	$17,609		
(B) Administrative service or other fees	9c(1)(B)			
(C) Other specific acquisition costs	9c(1)(C)			
(D) Other expenses	9c(1)(D)	$66,860		
(E) Taxes	9c(1)(E)	$2,696		
(F) Charges for risks or other contingencies	9c(1)(F)	$13,207		
(G) Other retention charges	9c(1)(G)			
(H) Total Retention			9c(1)(H)	$100,372
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)			9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			9d(1)	
(2) Claim reserves			9d(2)	
(3) Other reserves			9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).)			9e	

10 Nonexperience-rated contracts

a Total premiums or subscription charges paid to carrier	10a
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount	10b

Specify nature of costs below:

Part IV **Provision of Information**

11 Did the insurance company fail to provide any information necessary to complete Schedule A?	☐ Yes	☒ No
12 If the answer to line 11 is “Yes,” specify the information not provided.		

SCHEDULE A Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210 - 0110

2016

This Form is Open to Public Inspection

For the calendar plan year 2016 or fiscal plan year beginning January 01, 2016, and ending December 31, 2016

A Name of plan

AKUMIN HEALTH PLAN

B Three-digit plan number (PN) 501

C Plan sponsor's name as shown on line 2a of Form 5500

AKUMIN

D Employer Identification Number (EIN) [redacted]3204

Part I · **Information Concerning Insurance Contract Coverage, Fees, and Commissions.** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information

(a) Name of insurance carrier

HEALTH OPTIONS

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Aproximate number of persons covered at end of policy or contract year	Policy or contract year **(f)** From	**(g)** To
[redacted]3696	95089	B7825	79	01/01/2016	12/31/2016

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid: $22,307

(b) Total amount of fees paid:

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC
1560 SAWGRASS CORPORATE PKWY #300
SUNRISE FL 33323

(b) Amount of sales and base commissions paid	Fees and other commissions paid **(c)** Amount	**(d)** Purpose	**(e)** Organization code
$22,307			3

Part II · **Investment and Annuity Contract Information**

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end **4**

5 Current value of plan's interest under this contract in separate accounts at year end **5**

6 Contracts With Allocated Funds

a State the basis of premium rates

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquision or retention of the contract or policy, enter amount **6d**

Specify nature of costs

e Type of contract **(1)** ☐ individual policies **(2)** ☐ group deferred annuity **(3)** ☐ other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract **(1)** ☐ deposit administration **(2)** ☐ immediate participation guarantee **(3)** ☐ guaranteed investment **(4)** ☐ other

b Balance at the end of the previous year **7b**

c Additions: (1) Contributions deposited during the year **7c(1)**

(2) Dividends and credits **7c(2)**

(3) Interest credited during the year **7c(3)**

(4) Transferred from separate account **7c(4)**

(5) Other (specify below)	7c(5)		
(6) Total additions		7c(6)	
d Total of balance and additions (add **b** and **c** (6))		7d	
e Deductions:			
(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
(2) Administration charge made by carrier	7e(2)		
(3) Transferred to separate account	7e(3)		
(4) Other (specify below)	7e(4)		
(5) Total deductions		7e(5)	
f Balance at the end of the current year (subtract **e**(5) from **d**)		7f	

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

a ☒ Health (other than dental or vision)	**b** ☐ Dental	**c** ☐ Vision	**d** ☐ Life insurance
e ☐ Temporary disablility (accident and sickness)	**f** ☐ Long-term disability	**g** ☐ Supplemental unemployment	**h** ☒ Prescription drug
i ☐ Stop loss (large deductible)	**j** ☒ HMO contract	**k** ☐ PPO contract	**l** ☐ Indemnity contract
m ☐ Other (specify)			

9 Experience related contracts

a Premiums: (1) Amount received	9a(1)	$557,666		
(2) Increase (decrease) in amount due but unpaid	9a(2)			
(3) Increase (decrease) in unearned premium reserve	9a(3)			
(4) Earned ((1)+(2)-(3))			9a(4)	$557,666
b Benefit charges: (1) Claims paid	9b(1)	$456,728		
(2) Increase (decrease) in claim reserves	9b(2)			
(3) Incurred claims (add (1) and (2))			9b(3)	$456,728
(4) Claims charged			9b(4)	$456,728
c Remainder of premium: (1) Retention charges (on an accrual basis) –				
(A) Commissions	9c(1)(A)	$22,307		
(B) Administrative service or other fees	9c(1)(B)			
(C) Other specific acquisition costs	9c(1)(C)			
(D) Other expenses	9c(1)(D)	$61,901		
(E) Taxes	9c(1)(E)			
(F) Charges for risks or other contingencies	9c(1)(F)	$16,730		
(G) Other retention charges	9c(1)(G)			
(H) Total Retention			9c(1)(H)	$100,938
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)			9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			9d(1)	
(2) Claim reserves			9d(2)	
(3) Other reserves			9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).)			9e	

10 Nonexperience-rated contracts

a Total premiums or subscription charges paid to carrier	10a
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount	10b

Specify nature of costs below:

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is “Yes,” specify the information not provided.

SCHEDULE A Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210 - 0110

2016

This Form is Open to Public Inspection

For the calendar plan year 2016 or fiscal plan year beginning January 01, 2016, and ending December 31, 2016

A Name of plan

AKUMIN HEALTH PLAN

B Three-digit plan number (PN) 501

C Plan sponsor's name as shown on line 2a of Form 5500

AKUMIN

D Employer Identification Number (EIN) [redacted]3204

Part I · **Information Concerning Insurance Contract Coverage, Fees, and Commissions.** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information

(a) Name of insurance carrier

FIDELITY SECURITY LIFE INSURANCE COMPANY

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Aproximate number of persons covered at end of policy or contract year	Policy or contract year **(f)** From	**(g)** To
[redacted]9844	71870	9943572	245	01/01/2016	12/31/2016

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid: $972

(b) Total amount of fees paid:

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC
4565 PAYSPHERE CIRCLE
CHICAGO IL 60674

(b) Amount of sales and base commissions paid	Fees and other commissions paid **(c)** Amount	**(d)** Purpose	**(e)** Organization code
$972			3

Part II · **Investment and Annuity Contract Information**

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end **4**

5 Current value of plan's interest under this contract in separate accounts at year end **5**

6 Contracts With Allocated Funds

a State the basis of premium rates

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquision or retention of the contract or policy, enter amount **6d**

Specify nature of costs

e Type of contract **(1)** ☐ individual policies **(2)** ☐ group deferred annuity **(3)** ☐ other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract **(1)** ☐ deposit administration **(2)** ☐ immediate participation guarantee **(3)** ☐ guaranteed investment **(4)** ☐ other

b Balance at the end of the previous year **7b**

c Additions: (1) Contributions deposited during the year **7c(1)**

(2) Dividends and credits **7c(2)**

(3) Interest credited during the year **7c(3)**

(4) Transferred from separate account **7c(4)**

(5) Other (specify below) **7c(5)**

(6) Total additions **7c(6)**

d Total of balance and additions (add **b** and **c** (6)) **7d**

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)**

(2) Administration charge made by carrier **7e(2)**

(3) Transferred to separate account **7e(3)**

(4) Other (specify below) **7e(4)**

(5) Total deductions **7e(5)**

f Balance at the end of the current year (subtract **e**(5) from **d**) **7f**

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

a ☐ Health (other than dental or vision) **b** ☐ Dental **c** ☒ Vision **d** ☐ Life insurance

e ☐ Temporary disablility (accident and sickness) **f** ☐ Long-term disability **g** ☐ Supplemental unemployment **h** ☐ Prescription drug

i ☐ Stop loss (large deductible) **j** ☐ HMO contract **k** ☐ PPO contract **l** ☐ Indemnity contract

m ☐ Other (specify)

9 Experience related contracts

a Premiums: (1) Amount received **9a(1)**

(2) Increase (decrease) in amount due but unpaid **9a(2)**

(3) Increase (decrease) in unearned premium reserve **9a(3)**

(4) Earned ((1)+(2)-(3)) **9a(4)**

b Benefit charges: (1) Claims paid **9b(1)**

(2) Increase (decrease) in claim reserves **9b(2)**

(3) Incurred claims (add (1) and (2)) **9b(3)**

(4) Claims charged **9b(4)**

c Remainder of premium: (1) Retention charges (on an accrual basis) –

(A) Commissions **9c(1)(A)**

(B) Administrative service or other fees **9c(1)(B)**

(C) Other specific acquisition costs **9c(1)(C)**

(D) Other expenses **9c(1)(D)**

(E) Taxes **9c(1)(E)**

(F) Charges for risks or other contingencies **9c(1)(F)**

(G) Other retention charges **9c(1)(G)**

(H) Total Retention **9c(1)(H)**

(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.) **9c(2)**

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement **9d(1)**

(2) Claim reserves **9d(2)**

(3) Other reserves **9d(3)**

e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) **9e**

10 Nonexperience-rated contracts

a Total premiums or subscription charges paid to carrier **10a** $11,028

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount **10b**

Specify nature of costs below:

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is “Yes,” specify the information not provided.

SCHEDULE A Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210 - 0110

2016

This Form is Open to Public Inspection

For the calendar plan year 2016 or fiscal plan year beginning January 01, 2016, and ending December 31, 2016

A Name of plan

AKUMIN HEALTH PLAN

B Three-digit plan number (PN) 501

C Plan sponsor's name as shown on line 2a of Form 5500

AKUMIN

D Employer Identification Number (EIN) [redacted]3204

Part I · **Information Concerning Insurance Contract Coverage, Fees, and Commissions.** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information

(a) Name of insurance carrier

FIDELITY SECURITY LIFE INSURANCE COMPANY

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Aproximate number of persons covered at end of policy or contract year	Policy or contract year **(f)** From	**(g)** To
[redacted]9844	71870	9943580	0	01/01/2016	12/31/2016

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid: $19

(b) Total amount of fees paid:

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC
4565 PAYSPHERE CIRCLE
CHICAGO IL 60674

(b) Amount of sales and base commissions paid	Fees and other commissions paid **(c)** Amount	**(d)** Purpose	**(e)** Organization code
$19			3

Part II · **Investment and Annuity Contract Information**

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end **4**

5 Current value of plan's interest under this contract in separate accounts at year end **5**

6 Contracts With Allocated Funds

a State the basis of premium rates

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquision or retention of the contract or policy, enter amount **6d**

Specify nature of costs

e Type of contract **(1)** ☐ individual policies **(2)** ☐ group deferred annuity **(3)** ☐ other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract **(1)** ☐ deposit administration **(2)** ☐ immediate participation guarantee **(3)** ☐ guaranteed investment **(4)** ☐ other

b Balance at the end of the previous year **7b**

c Additions: (1) Contributions deposited during the year **7c(1)**

(2) Dividends and credits **7c(2)**

(3) Interest credited during the year **7c(3)**

(4) Transferred from separate account **7c(4)**

(5) Other (specify below) **7c(5)**

(6) Total additions **7c(6)**

d Total of balance and additions (add **b** and **c** (6)) **7d**

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)**

(2) Administration charge made by carrier **7e(2)**

(3) Transferred to separate account **7e(3)**

(4) Other (specify below) **7e(4)**

(5) Total deductions **7e(5)**

f Balance at the end of the current year (subtract **e**(5) from **d**) **7f**

Part III **Welfare Benefit Contract Information**

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

a ☐ Health (other than dental or vision) **b** ☐ Dental **c** ☒ Vision **d** ☐ Life insurance

e ☐ Temporary disablility (accident and sickness) **f** ☐ Long-term disability **g** ☐ Supplemental unemployment **h** ☐ Prescription drug

i ☐ Stop loss (large deductible) **j** ☐ HMO contract **k** ☐ PPO contract **l** ☐ Indemnity contract

m ☐ Other (specify)

9 Experience related contracts

a Premiums: (1) Amount received **9a(1)**

(2) Increase (decrease) in amount due but unpaid **9a(2)**

(3) Increase (decrease) in unearned premium reserve **9a(3)**

(4) Earned ((1)+(2)-(3)) **9a(4)**

b Benefit charges: (1) Claims paid **9b(1)**

(2) Increase (decrease) in claim reserves **9b(2)**

(3) Incurred claims (add (1) and (2)) **9b(3)**

(4) Claims charged **9b(4)**

c Remainder of premium: (1) Retention charges (on an accrual basis) –

(A) Commissions **9c(1)(A)**

(B) Administrative service or other fees **9c(1)(B)**

(C) Other specific acquisition costs **9c(1)(C)**

(D) Other expenses **9c(1)(D)**

(E) Taxes **9c(1)(E)**

(F) Charges for risks or other contingencies **9c(1)(F)**

(G) Other retention charges **9c(1)(G)**

(H) Total Retention **9c(1)(H)**

(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.) **9c(2)**

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement **9d(1)**

(2) Claim reserves **9d(2)**

(3) Other reserves **9d(3)**

e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) **9e**

10 Nonexperience-rated contracts

a Total premiums or subscription charges paid to carrier **10a** $160

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount **10b**

Specify nature of costs below:

Part IV **Provision of Information**

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is “Yes,” specify the information not provided.

SCHEDULE A Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210 - 0110

2016

This Form is Open to Public Inspection

For the calendar plan year 2016 or fiscal plan year beginning January 01, 2016, and ending December 31, 2016

A Name of plan

AKUMIN HEALTH PLAN

B Three-digit plan number (PN) 501

C Plan sponsor's name as shown on line 2a of Form 5500

AKUMIN

D Employer Identification Number (EIN) [redacted]3204

Part I · **Information Concerning Insurance Contract Coverage, Fees, and Commissions.** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information

(a) Name of insurance carrier

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Aproximate number of persons covered at end of policy or contract year	Policy or contract year **(f)** From	**(g)** To
[redacted]3390	64246	00508238	287	01/01/2016	12/31/2016

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	**(b)** Total amount of fees paid
$9,286	$1,917

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC
ONE INVESTORS WAY
NORWOOD MA 02062

(b) Amount of sales and base commissions paid	Fees and other commissions paid **(c)** Amount	**(d)** Purpose	**(e)** Organization code
$9,286	$1,917	FEES	3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. **Schedule A (Form 5500) 2016 v.092308.1**

Part II · **Investment and Annuity Contract Information** Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end **4**

5 Current value of plan's interest under this contract in separate accounts at year end **5**

6 Contracts With Allocated Funds

a State the basis of premium rates

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquision or retention of the contract or policy, enter amount **6d**

Specify nature of costs

e Type of contract **(1)** ☐ individual policies **(2)** ☐ group deferred annuity **(3)** ☐ other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract **(1)** ☐ deposit administration **(2)** ☐ immediate participation guarantee **(3)** ☐ guaranteed investment **(4)** ☐ other

b Balance at the end of the previous year **7b**

c Additions: (1) Contributions deposited during the year **7c(1)**

(2) Dividends and credits **7c(2)**

(3) Interest credited during the year **7c(3)**

(4) Transferred from separate account **7c(4)**

(5) Other (specify below) **7c(5)**

(6) Total additions **7c(6)**

d Total of balance and additions (add **b** and **c** (6)) **7d**

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)**

(2) Administration charge made by carrier **7e(2)**

(3) Transferred to separate account **7e(3)**

(4) Other (specify below) **7e(4)**

(5) Total deductions **7e(5)**

f Balance at the end of the current year (subtract **e**(5) from **d**) **7f**

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

a ☐ Health (other than dental or vision) **b** ☐ Dental **c** ☐ Vision **d** ☒ Life insurance

e ☒ Temporary disablility (accident and sickness) **f** ☒ Long-term disability **g** ☐ Supplemental unemployment **h** ☐ Prescription drug

i ☐ Stop loss (large deductible) **j** ☐ HMO contract **k** ☐ PPO contract **l** ☐ Indemnity contract

m ☒ Other (specify) ACCIDENTAL DEATH AND DISMEMBERMENT

9 Experience related contracts

a Premiums: (1) Amount received **9a(1)**

(2) Increase (decrease) in amount due but unpaid **9a(2)**

(3) Increase (decrease) in unearned premium reserve **9a(3)**

(4) Earned ((1)+(2)-(3)) **9a(4)**

b Benefit charges: (1) Claims paid **9b(1)**

(2) Increase (decrease) in claim reserves **9b(2)**

(3) Incurred claims (add (1) and (2)) **9b(3)**

(4) Claims charged **9b(4)**

c Remainder of premium: (1) Retention charges (on an accrual basis) –

(A) Commissions **9c(1)(A)**

(B) Administrative service or other fees **9c(1)(B)**

(C) Other specific acquisition costs **9c(1)(C)**

(D) Other expenses **9c(1)(D)**

(E) Taxes **9c(1)(E)**

(F) Charges for risks or other contingencies **9c(1)(F)**

(G) Other retention charges **9c(1)(G)**

(H) Total Retention **9c(1)(H)**

(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.) **9c(2)**

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement **9d(1)**

(2) Claim reserves **9d(2)**

(3) Other reserves **9d(3)**

e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) **9e**

10 Nonexperience-rated contracts

a Total premiums or subscription charges paid to carrier **10a** $92,861

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount **10b**

Specify nature of costs below:

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is “Yes,” specify the information not provided.

SCHEDULE A Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210 - 0110

2016

This Form is Open to Public Inspection

For the calendar plan year 2016 or fiscal plan year beginning January 01, 2016, and ending December 31, 2016

A Name of plan

AKUMIN HEALTH PLAN

B Three-digit plan number (PN) 501

C Plan sponsor's name as shown on line 2a of Form 5500

AKUMIN

D Employer Identification Number (EIN) [redacted]3204

Part I · **Information Concerning Insurance Contract Coverage, Fees, and Commissions.** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information

(a) Name of insurance carrier

HUMANA INSURANCE COMPANY

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Aproximate number of persons covered at end of policy or contract year	Policy or contract year **(f)** From	**(g)** To
[redacted]3473	73288	749790	173	01/01/2016	12/31/2016

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid: $6,342

(b) Total amount of fees paid:

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC
4565 PAYSPHERE CIRCLE
CHICAGO IL 60674

(b) Amount of sales and base commissions paid	Fees and other commissions paid **(c)** Amount	**(d)** Purpose	**(e)** Organization code
$6,342			3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. **Schedule A (Form 5500) 2016 v.092308.1**

Part II · **Investment and Annuity Contract Information** Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end **4**

5 Current value of plan's interest under this contract in separate accounts at year end **5**

6 Contracts With Allocated Funds

a State the basis of premium rates

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquision or retention of the contract or policy, enter amount **6d**

Specify nature of costs

e Type of contract **(1)** ☐ individual policies **(2)** ☐ group deferred annuity **(3)** ☐ other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract **(1)** ☐ deposit administration **(2)** ☐ immediate participation guarantee **(3)** ☐ guaranteed investment **(4)** ☐ other

b Balance at the end of the previous year **7b**

c Additions: (1) Contributions deposited during the year **7c(1)**

(2) Dividends and credits **7c(2)**

(3) Interest credited during the year **7c(3)**

(4) Transferred from separate account **7c(4)**

(5) Other (specify below) **7c(5)**

(6) Total additions **7c(6)**

d Total of balance and additions (add **b** and **c** (6)) **7d**

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)**

(2) Administration charge made by carrier **7e(2)**

(3) Transferred to separate account **7e(3)**

(4) Other (specify below) **7e(4)**

(5) Total deductions **7e(5)**

f Balance at the end of the current year (subtract **e**(5) from **d**) **7f**

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

a ☐ Health (other than dental or vision) **b** ☒ Dental **c** ☐ Vision **d** ☐ Life insurance

e ☐ Temporary disablility (accident and sickness) **f** ☐ Long-term disability **g** ☐ Supplemental unemployment **h** ☐ Prescription drug

i ☐ Stop loss (large deductible) **j** ☐ HMO contract **k** ☐ PPO contract **l** ☐ Indemnity contract

m ☐ Other (specify)

9 Experience related contracts

a Premiums: (1) Amount received **9a(1)**

(2) Increase (decrease) in amount due but unpaid **9a(2)**

(3) Increase (decrease) in unearned premium reserve **9a(3)**

(4) Earned ((1)+(2)-(3)) **9a(4)**

b Benefit charges: (1) Claims paid **9b(1)**

(2) Increase (decrease) in claim reserves **9b(2)**

(3) Incurred claims (add (1) and (2)) **9b(3)**

(4) Claims charged **9b(4)**

c Remainder of premium: (1) Retention charges (on an accrual basis) –

(A) Commissions **9c(1)(A)**

(B) Administrative service or other fees **9c(1)(B)**

(C) Other specific acquisition costs **9c(1)(C)**

(D) Other expenses **9c(1)(D)**

(E) Taxes **9c(1)(E)**

(F) Charges for risks or other contingencies **9c(1)(F)**

(G) Other retention charges **9c(1)(G)**

(H) Total Retention **9c(1)(H)**

(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.) **9c(2)**

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement **9d(1)**

(2) Claim reserves **9d(2)**

(3) Other reserves **9d(3)**

e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) **9e**

10 Nonexperience-rated contracts

a Total premiums or subscription charges paid to carrier **10a** $68,503

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount **10b**

Specify nature of costs below:

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is “Yes,” specify the information not provided.

Form 5500

Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

OMB Nos. 1210 - 0110
1210 - 0089

2016

This Form is Open to Public Inspection

Complete all entries in accordance with the instructions to the Form 5500.

Part I · Annual Report Identification Information

For calendar plan year 2016 or fiscal plan year beginning April 01, 2016 , and ending March 31, 2017

A a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions)for ☐ a multiemployer plan; ☐ a multiple-employer plan; ☐ a DFE (specify) ☒ a single-employer plan;

B This return/report is: ☐ the first return/report; ☐ the final return/report; ☐ an amended return/report; ☐ a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here ☐

D Check box if filling under: ☐ Form 5558; ☐ automatic extension; ☐ the DFVC program; ☐ special extension (enter description)

Part II · Basic Plan Information – enter all requested information.

1a Name of plan

DUFFY'S SPORTS GRILL HEALTH AND WELFARE PLAN

1b Three-digit plan number (PN) 501

1c Effective date of plan February 01, 2001

2a Plan sponsor's name and address, including room or suite number (Employer, if for a single-employer plan)

DUFFY'S SPORTS GRILL
1926 10TH AVENUE NORTH, SUITE 300
LAKE WORTH FL 33461

2b Employer Identification Number (EIN) [redacted]3744

2c Sponsor's telephone number 561-585-6685

2d Business code (see instructions) 722511

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.
Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

Signature of plan administrator	Date	Enter name of individual signing as plan administrator
Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
Signature of DFE	Date	Enter name of individual signing as DFE

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. **Form 5500 (2016) v.092308.1**

3a Plan administrator's name and address (if same as plan sponsor, enter"Same")

3b Administrator's EIN

3c Administrator's telephone number

4	If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below: **a** Sponsor's name		**4b** EIN **4c** PN
5	Total number of participants at the beginning of the plan year	**5**	340
6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans only complete lines **6a(1), 6a(2), 6b, 6c,** and **6d**)		
a(1)	Total active number of participants at the beginning of the plan year	**6a(1)**	339
a(2)	Total active number of participants at the end of the plan year	**6a(2)**	
b	Retired or separated participants receiving benefits	**6b**	3
c	Other retired or separated participants entitled to future benefits	**6c**	
d	Subtotal. Add lines **6a(2), 6b,** and **6c**	**6d**	346
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**6e**	
f	Total. Add lines **6d** and **6e**	**6f**	
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	0

8a If the plan provides **pension benefits**, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:

b If the plan provides **welfare benefits**, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:

4A **4B** **4D** **4E** **4F** **4L**

9a Plan funding arrangement (check all that apply)
- **(1)** [X] Insurance
- **(2)** [ ] Section 412(e)(3) insurance contracts
- **(3)** [ ] Trust
- **(4)** [ ] General assets of the sponsor

9b Plan benefit arrangement (check all that apply)
- **(1)** [X] Insurance
- **(2)** [ ] Section 412(e)(3) insurance contracts
- **(3)** [ ] Trust
- **(4)** [ ] General assets of the sponsor

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached,and, where indicated, enter the number attached (See instructions)

a Pension Schedules
- **(1)** [ ] **R** (Retirement Plan Information)
- **(2)** [ ] **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information)- signed by the plan actuary
- **(3)** [ ] **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

b General Schedules
- **(1)** [ ] **H** (Financial Information)
- **(2)** [ ] **I** (Financial Information – Small Plan)
- **(3)** [X] 5 **A** (Insurance Information)
- **(4)** [ ] **C** (Service Provider Information)
- **(5)** [ ] **D** (DFE/Participating Plan Information)
- **(6)** [ ] **G** (Financial Transaction Schedules)

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

11a If the plan provides welfare benefits, was the plan subject to Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2)..... [ ] Yes [X] No
If "Yes" is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with M-1 filing requirements? (See instructions and 29 CFR 2520.101-2)..... [ ] Yes [ ] No

11c Enter the Receipt Confirmation Code for the 2016 Form M-1 annual report. If the plan was not required to file the 2016 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.) Receipt Confirmation Code

SCHEDULE A Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210 - 0110

2016

This Form is Open to Public Inspection

For the calendar plan year 2016 or fiscal plan year beginning April 01, 2016, and ending March 31, 2017

A Name of plan

DUFFY'S SPORTS GRILL HEALTH AND WELFARE PLAN

B Three-digit plan number (PN) 501

C Plan sponsor's name as shown on line 2a of Form 5500

DUFFY'S SPORTS GRILL

D Employer Identification Number (EIN) [redacted]3744

Part I · **Information Concerning Insurance Contract Coverage, Fees, and Commissions.** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information

(a) Name of insurance carrier

BLUE CROSS BLUE SHIELD OF FLORIDA

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Aproximate number of persons covered at end of policy or contract year	Policy or contract year (f) From	(g) To
[redacted]5694	98167	B8302	283	04/01/2016	03/31/2017

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid: $72,242

(b) Total amount of fees paid

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC
1560 SAWGRASS CORPORATE PKWY SUITE
SUNRISE FL 33323

(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount	(d) Purpose	(e) Organization code
$72,242			3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. **Schedule A (Form 5500) 2016 v.092308.1**

Part II · **Investment and Annuity Contract Information** Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end **4**

5 Current value of plan's interest under this contract in separate accounts at year end **5**

6 Contracts With Allocated Funds

a State the basis of premium rates

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquision or retention of the contract or policy, enter amount **6d**

Specify nature of costs

e Type of contract **(1)** ☐ individual policies **(2)** ☐ group deferred annuity **(3)** ☐ other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract **(1)** ☐ deposit administration **(2)** ☐ immediate participation guarantee **(3)** ☐ guaranteed investment **(4)** ☐ other

b Balance at the end of the previous year **7b**

c Additions: (1) Contributions deposited during the year **7c(1)**

(2) Dividends and credits **7c(2)**

(3) Interest credited during the year **7c(3)**

(4) Transferred from separate account **7c(4)**

(5) Other (specify below) **7c(5)**

(6) Total additions **7c(6)**

d Total of balance and additions (add **b** and **c** (6)) **7d**

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)**

(2) Administration charge made by carrier **7e(2)**

(3) Transferred to separate account **7e(3)**

(4) Other (specify below) **7e(4)**

(5) Total deductions **7e(5)**

f Balance at the end of the current year (subtract **e**(5) from **d**) **7f**

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

a ☒ Health (other than dental or vision) **b** ☐ Dental **c** ☐ Vision **d** ☐ Life insurance

e ☐ Temporary disablility (accident and sickness) **f** ☐ Long-term disability **g** ☐ Supplemental unemployment **h** ☒ Prescription drug

i ☐ Stop loss (large deductible) **j** ☐ HMO contract **k** ☒ PPO contract **l** ☐ Indemnity contract

m ☐ Other (specify)

9 Experience related contracts

a Premiums: (1) Amount received **9a(1)** $1,444,833

(2) Increase (decrease) in amount due but unpaid **9a(2)**

(3) Increase (decrease) in unearned premium reserve **9a(3)**

(4) Earned ((1)+(2)-(3)) **9a(4)** $1,444,833

b Benefit charges: (1) Claims paid **9b(1)** $1,094,605

(2) Increase (decrease) in claim reserves **9b(2)**

(3) Incurred claims (add (1) and (2)) **9b(3)** $1,094,605

(4) Claims charged **9b(4)** $1,094,605

c Remainder of premium: (1) Retention charges (on an accrual basis) –

(A) Commissions **9c(1)(A)** $72,242

(B) Administrative service or other fees **9c(1)(B)**

(C) Other specific acquisition costs **9c(1)(C)**

(D) Other expenses **9c(1)(D)** $178,292

(E) Taxes **9c(1)(E)** $8,669

(F) Charges for risks or other contingencies **9c(1)(F)** $91,024

(G) Other retention charges **9c(1)(G)**

(H) Total Retention **9c(1)(H)** $350,227

(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.) **9c(2)**

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement **9d(1)**

(2) Claim reserves **9d(2)**

(3) Other reserves **9d(3)**

e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) **9e**

10 Nonexperience-rated contracts

a Total premiums or subscription charges paid to carrier **10a**

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount **10b**

Specify nature of costs below:

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is “Yes,” specify the information not provided.

SCHEDULE A Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210 - 0110

2016

This Form is Open to Public Inspection

For the calendar plan year 2016 or fiscal plan year beginning April 01, 2016, and ending March 31, 2017

A Name of plan

DUFFY'S SPORTS GRILL HEALTH AND WELFARE PLAN

B Three-digit plan number (PN) 501

C Plan sponsor's name as shown on line 2a of Form 5500

DUFFY'S SPORTS GRILL

D Employer Identification Number (EIN) [redacted]3744

Part I **Information Concerning Insurance Contract Coverage, Fees, and Commissions.** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information

(a) Name of insurance carrier

COLONIAL LIFE AND ACCIDENT INSURANCE COMPANY

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Aproximate number of persons covered at end of policy or contract year	Policy or contract year **(f)** From	**(g)** To
[redacted]4607	62049	E3950466	2	04/01/2016	03/31/2017

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid $98

(b) Total amount of fees paid

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC
4565 PAYSPHERE CIRCLE
CHICAGO IL 60674

(b) Amount of sales and base commissions paid	Fees and other commissions paid **(c)** Amount	**(d)** Purpose	**(e)** Organization code
$65			3

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

CREATIVE BENEFIT CONSULTANTS INC
18214 102ND WAY S
BOCA RATON FL 33498

(b) Amount of sales and base commissions paid	Fees and other commissions paid **(c)** Amount	**(d)** Purpose	**(e)** Organization code
$17			3

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

STALTARE BENEFITS INC
700 E ATLANTIC BLVD
POMPANO BEACH FL 33060

(b) Amount of sales and base commissions paid	Fees and other commissions paid **(c)** Amount	**(d)** Purpose	**(e)** Organization code
$16			3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. **Schedule A (Form 5500) 2016**
v.092308.1

Part II **Investment and Annuity Contract Information**
Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	**4**
5	Current value of plan's interest under this contract in separate accounts at year end	**5**
6	Contracts With Allocated Funds	
a	State the basis of premium rates	
b	Premiums paid to carrier	**6b**
c	Premiums due but unpaid at the end of the year	**6c**
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquision or retention of the contract or policy, enter amount Specify nature of costs	**6d**
e	Type of contract **(1)** ☐ individual policies **(2)** ☐ group deferred annuity **(3)** ☐ other (specify)	
f	If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ☐	
7	Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)	
a	Type of contract **(1)** ☐ deposit administration **(2)** ☐ immediate participation guarantee **(3)** ☐ guaranteed investment **(4)** ☐ other	
b	Balance at the end of the previous year	**7b**
c	Additions: (1) Contributions deposited during the year	**7c(1)**
	(2) Dividends and credits	**7c(2)**
	(3) Interest credited during the year	**7c(3)**
	(4) Transferred from separate account	**7c(4)**
	(5) Other (specify below)	**7c(5)**
	(6) Total additions	**7c(6)**
d	Total of balance and additions (add **b** and **c** (6))	**7d**
e	Deductions:	
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**
	(2) Administration charge made by carrier	**7e(2)**
	(3) Transferred to separate account	**7e(3)**
	(4) Other (specify below)	**7e(4)**
	(5) Total deductions	**7e(5)**
f	Balance at the end of the current year (subtract **e**(5) from **d**)	**7f**

Part III **Welfare Benefit Contract Information**
If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

a ☒ Health (other than dental or vision)	**b** ☐ Dental	**c** ☐ Vision	**d** ☐ Life insurance
e ☒ Temporary disablility (accident and sickness)	**f** ☐ Long-term disability	**g** ☐ Supplemental unemployment	**h** ☐ Prescription drug
i ☐ Stop loss (large deductible)	**j** ☐ HMO contract	**k** ☐ PPO contract	**l** ☒ Indemnity contract
m ☐ Other (specify)			

9	Experience related contracts		
a	Premiums: (1) Amount received	**9a(1)**	
	(2) Increase (decrease) in amount due but unpaid	**9a(2)**	
	(3) Increase (decrease) in unearned premium reserve	**9a(3)**	
	(4) Earned ((1)+(2)-(3))		**9a(4)**
b	Benefit charges: (1) Claims paid	**9b(1)**	
	(2) Increase (decrease) in claim reserves	**9b(2)**	
	(3) Incurred claims (add (1) and (2))		**9b(3)**
	(4) Claims charged		**9b(4)**
c	Remainder of premium: (1) Retention charges (on an accrual basis) –		
	(A) Commissions	**9c(1)(A)**	
	(B) Administrative service or other fees	**9c(1)(B)**	
	(C) Other specific acquisition costs	**9c(1)(C)**	
	(D) Other expenses	**9c(1)(D)**	
	(E) Taxes	**9c(1)(E)**	
	(F) Charges for risks or other contingencies	**9c(1)(F)**	
	(G) Other retention charges	**9c(1)(G)**	
	(H) Total Retention		**9c(1)(H)**
	(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)		**9c(2)**
d	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		**9d(1)**
	(2) Claim reserves		**9d(2)**
	(3) Other reserves		**9d(3)**
e	Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).)		**9e**
10	Nonexperience-rated contracts		
a	Total premiums or subscription charges paid to carrier		**10a** $1,501
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or		**10b**

retention of the contract or policy, other than reported in Part I, item 2 above, report amount
Specify nature of costs below:

Part IV · Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is “Yes,” specify the information not provided.

SCHEDULE A Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210 - 0110

2016

This Form is Open to Public Inspection

For the calendar plan year 2016 or fiscal plan year beginning April 01, 2016, and ending March 31, 2017

A Name of plan

DUFFY'S SPORTS GRILL HEALTH AND WELFARE PLAN

B Three-digit plan number (PN) 501

C Plan sponsor's name as shown on line 2a of Form 5500

DUFFY'S SPORTS GRILL

D Employer Identification Number (EIN) [redacted]3744

Part I · **Information Concerning Insurance Contract Coverage, Fees, and Commissions.** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information

(a) Name of insurance carrier

FIDELITY SECURITY LIFE INSURANCE COMPANY

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Aproximate number of persons covered at end of policy or contract year	Policy or contract year **(f)** From	**(g)** To
[redacted]9844	71870	97480211001	148	04/01/2016	03/31/2017

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid: $991

(b) Total amount of fees paid:

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC
4565 PAYSPHERE CIRCLE
CHICAGO IL 60674

(b) Amount of sales and base commissions paid	Fees and other commissions paid **(c)** Amount	**(d)** Purpose	**(e)** Organization code
$991			3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. **Schedule A (Form 5500) 2016 v.092308.1**

Part II · **Investment and Annuity Contract Information**

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end **4**

5 Current value of plan's interest under this contract in separate accounts at year end **5**

6 Contracts With Allocated Funds

a State the basis of premium rates

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquision or retention of the contract or policy, enter amount **6d**

Specify nature of costs

e Type of contract **(1)** ☐ individual policies **(2)** ☐ group deferred annuity **(3)** ☐ other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract **(1)** ☐ deposit administration **(2)** ☐ immediate participation guarantee **(3)** ☐ guaranteed investment **(4)** ☐ other

b Balance at the end of the previous year **7b**

c Additions: (1) Contributions deposited during the year **7c(1)**

(2) Dividends and credits **7c(2)**

(3) Interest credited during the year **7c(3)**

(4) Transferred from separate account **7c(4)**

(5) Other (specify below) **7c(5)**

(6) Total additions **7c(6)**

d Total of balance and additions (add **b** and **c** (6)) **7d**

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)**

(2) Administration charge made by carrier **7e(2)**

(3) Transferred to separate account **7e(3)**

(4) Other (specify below) **7e(4)**

(5) Total deductions **7e(5)**

f Balance at the end of the current year (subtract **e**(5) from **d**) **7f**

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

a ☐ Health (other than dental or vision) **b** ☐ Dental **c** ☒ Vision **d** ☐ Life insurance

e ☐ Temporary disablility (accident and sickness) **f** ☐ Long-term disability **g** ☐ Supplemental unemployment **h** ☐ Prescription drug

i ☐ Stop loss (large deductible) **j** ☐ HMO contract **k** ☐ PPO contract **l** ☐ Indemnity contract

m ☐ Other (specify)

9 Experience related contracts

a Premiums: (1) Amount received **9a(1)**

(2) Increase (decrease) in amount due but unpaid **9a(2)**

(3) Increase (decrease) in unearned premium reserve **9a(3)**

(4) Earned ((1)+(2)-(3)) **9a(4)**

b Benefit charges: (1) Claims paid **9b(1)**

(2) Increase (decrease) in claim reserves **9b(2)**

(3) Incurred claims (add (1) and (2)) **9b(3)**

(4) Claims charged **9b(4)**

c Remainder of premium: (1) Retention charges (on an accrual basis) –

(A) Commissions **9c(1)(A)**

(B) Administrative service or other fees **9c(1)(B)**

(C) Other specific acquisition costs **9c(1)(C)**

(D) Other expenses **9c(1)(D)**

(E) Taxes **9c(1)(E)**

(F) Charges for risks or other contingencies **9c(1)(F)**

(G) Other retention charges **9c(1)(G)**

(H) Total Retention **9c(1)(H)**

(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.) **9c(2)**

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement **9d(1)**

(2) Claim reserves **9d(2)**

(3) Other reserves **9d(3)**

e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) **9e**

10 Nonexperience-rated contracts

a Total premiums or subscription charges paid to carrier **10a** $13,363

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount **10b**

Specify nature of costs below:

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is “Yes,” specify the information not provided.

SCHEDULE A Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210 - 0110

2016

This Form is Open to Public Inspection

For the calendar plan year 2016 or fiscal plan year beginning April 01, 2016, and ending March 31, 2017

A Name of plan

DUFFY'S SPORTS GRILL HEALTH AND WELFARE PLAN

B Three-digit plan number (PN) 501

C Plan sponsor's name as shown on line 2a of Form 5500

DUFFY'S SPORTS GRILL

D Employer Identification Number (EIN) [redacted]3744

Part I · **Information Concerning Insurance Contract Coverage, Fees, and Commissions.** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information

(a) Name of insurance carrier

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Aproximate number of persons covered at end of policy or contract year	Policy or contract year (f) From	(g) To
[redacted]3390	64246	00476398	158	04/01/2016	03/31/2017

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
$7,863	$646

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC
ONE INVESTORS WAY
NORWOOD MA 02062

(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount	(d) Purpose	(e) Organization code
$7,863	$646	FEES PAID	3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. **Schedule A (Form 5500) 2016 v.092308.1**

Part II · **Investment and Annuity Contract Information**

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end **4**

5 Current value of plan's interest under this contract in separate accounts at year end **5**

6 Contracts With Allocated Funds

a State the basis of premium rates

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquision or retention of the contract or policy, enter amount **6d**

Specify nature of costs

e Type of contract **(1)** ☐ individual policies **(2)** ☐ group deferred annuity **(3)** ☐ other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract **(1)** ☐ deposit administration **(2)** ☐ immediate participation guarantee **(3)** ☐ guaranteed investment **(4)** ☐ other

b Balance at the end of the previous year **7b**

c Additions: (1) Contributions deposited during the year **7c(1)**

(2) Dividends and credits **7c(2)**

(3) Interest credited during the year **7c(3)**

(4) Transferred from separate account **7c(4)**

(5) Other (specify below) **7c(5)**

(6) Total additions **7c(6)**

d Total of balance and additions (add **b** and **c** (6)) **7d**

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)**

(2) Administration charge made by carrier **7e(2)**

(3) Transferred to separate account **7e(3)**

(4) Other (specify below) **7e(4)**

(5) Total deductions **7e(5)**

f Balance at the end of the current year (subtract **e**(5) from **d**) **7f**

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

a ☐ Health (other than dental or vision) **b** ☒ Dental **c** ☐ Vision **d** ☐ Life insurance

e ☐ Temporary disablility (accident and sickness) **f** ☐ Long-term disability **g** ☐ Supplemental unemployment **h** ☐ Prescription drug

i ☐ Stop loss (large deductible) **j** ☐ HMO contract **k** ☐ PPO contract **l** ☐ Indemnity contract

m ☐ Other (specify)

9 Experience related contracts

a Premiums: (1) Amount received **9a(1)**

(2) Increase (decrease) in amount due but unpaid **9a(2)**

(3) Increase (decrease) in unearned premium reserve **9a(3)**

(4) Earned ((1)+(2)-(3)) **9a(4)**

b Benefit charges: (1) Claims paid **9b(1)**

(2) Increase (decrease) in claim reserves **9b(2)**

(3) Incurred claims (add (1) and (2)) **9b(3)**

(4) Claims charged **9b(4)**

c Remainder of premium: (1) Retention charges (on an accrual basis) –

(A) Commissions **9c(1)(A)**

(B) Administrative service or other fees **9c(1)(B)**

(C) Other specific acquisition costs **9c(1)(C)**

(D) Other expenses **9c(1)(D)**

(E) Taxes **9c(1)(E)**

(F) Charges for risks or other contingencies **9c(1)(F)**

(G) Other retention charges **9c(1)(G)**

(H) Total Retention **9c(1)(H)**

(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.) **9c(2)**

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement **9d(1)**

(2) Claim reserves **9d(2)**

(3) Other reserves **9d(3)**

e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) **9e**

10 Nonexperience-rated contracts

a Total premiums or subscription charges paid to carrier **10a** $78,595

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount **10b**

Specify nature of costs below:

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is “Yes,” specify the information not provided.

SCHEDULE A Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210 - 0110

2016

This Form is Open to Public Inspection

For the calendar plan year 2016 or fiscal plan year beginning April 01, 2016, and ending March 31, 2017

A Name of plan

DUFFY'S SPORTS GRILL HEALTH AND WELFARE PLAN

B Three-digit plan number (PN) 501

C Plan sponsor's name as shown on line 2a of Form 5500

DUFFY'S SPORTS GRILL

D Employer Identification Number (EIN) [redacted]3744

Part I · **Information Concerning Insurance Contract Coverage, Fees, and Commissions.** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information

(a) Name of insurance carrier

SUN LIFE ASSURANCE COMPANY OF CANADA

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Aproximate number of persons covered at end of policy or contract year	Policy or contract year **(f)** From	**(g)** To
[redacted]080	80802	243948	240	04/01/2016	03/31/2017

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid: $3,456

(b) Total amount of fees paid:

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC
4565 PAYSPHERE CIRCLE
CHICAGO IL 60674

(b) Amount of sales and base commissions paid	Fees and other commissions paid **(c)** Amount	**(d)** Purpose	**(e)** Organization code
$3,456			3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. **Schedule A (Form 5500) 2016 v.092308.1**

Part II · **Investment and Annuity Contract Information** Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end **4**

5 Current value of plan's interest under this contract in separate accounts at year end **5**

6 Contracts With Allocated Funds

a State the basis of premium rates

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquision or retention of the contract or policy, enter amount **6d**

Specify nature of costs

e Type of contract **(1)** ☐ individual policies **(2)** ☐ group deferred annuity **(3)** ☐ other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract **(1)** ☐ deposit administration **(2)** ☐ immediate participation guarantee **(3)** ☐ guaranteed investment **(4)** ☐ other

b Balance at the end of the previous year **7b**

c Additions: (1) Contributions deposited during the year **7c(1)**

(2) Dividends and credits **7c(2)**

(3) Interest credited during the year **7c(3)**

(4) Transferred from separate account **7c(4)**

(5) Other (specify below) **7c(5)**

(6) Total additions **7c(6)**

d Total of balance and additions (add **b** and **c** (6)) **7d**

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)**

(2) Administration charge made by carrier **7e(2)**

(3) Transferred to separate account **7e(3)**

(4) Other (specify below) **7e(4)**

(5) Total deductions **7e(5)**

f Balance at the end of the current year (subtract **e**(5) from **d**) **7f**

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

a ☐ Health (other than dental or vision) **b** ☐ Dental **c** ☐ Vision **d** ☒ Life insurance

e ☐ Temporary disablility (accident and sickness) **f** ☐ Long-term disability **g** ☐ Supplemental unemployment **h** ☐ Prescription drug

i ☐ Stop loss (large deductible) **j** ☐ HMO contract **k** ☐ PPO contract **l** ☐ Indemnity contract

m ☒ Other (specify) ACCIDENTAL DEATH AND DISMEMBERMENT EMPLOYEE ASSISTANCE PROGRAM

9 Experience related contracts

a Premiums: (1) Amount received **9a(1)**

(2) Increase (decrease) in amount due but unpaid **9a(2)**

(3) Increase (decrease) in unearned premium reserve **9a(3)**

(4) Earned ((1)+(2)-(3)) **9a(4)**

b Benefit charges: (1) Claims paid **9b(1)**

(2) Increase (decrease) in claim reserves **9b(2)**

(3) Incurred claims (add (1) and (2)) **9b(3)**

(4) Claims charged **9b(4)**

c Remainder of premium: (1) Retention charges (on an accrual basis) –

(A) Commissions **9c(1)(A)**

(B) Administrative service or other fees **9c(1)(B)**

(C) Other specific acquisition costs **9c(1)(C)**

(D) Other expenses **9c(1)(D)**

(E) Taxes **9c(1)(E)**

(F) Charges for risks or other contingencies **9c(1)(F)**

(G) Other retention charges **9c(1)(G)**

(H) Total Retention **9c(1)(H)**

(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.) **9c(2)**

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement **9d(1)**

(2) Claim reserves **9d(2)**

(3) Other reserves **9d(3)**

e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) **9e**

10 Nonexperience-rated contracts

a Total premiums or subscription charges paid to carrier **10a** $29,211

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount **10b**

Specify nature of costs below:

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is “Yes,” specify the information not provided.